Advanced Therapeutics

1398 Queen St. E.
Toronto, Ont. M4L 1C9
416-469-3879

Patient Information

Name_____ Date_____

Date of Birth_____ Employer_____

Address_____ Work phone#_____

City_____ Work duties_____

Postal Code_____ _____

E-mail_____ Emergency contact_____

Home phone#_____ Phone_____

Cell phone#_____ Referred to our office by_____

Please list other Health care providers:

Type of Health care	Name	Phone #

YES/NO Can we send you information regarding upcoming office events via email?

Purpose of this appointment:

_____

_____

_____

MEDICAL HISTORY

List any accidents/falls you have had through childhood (include work/auto).

1._____

2._____

3._____

4._____

List any major medical surgeries you have had.

1._____

2._____

3._____

4._____

Have you had any fractures?_____ If so, where_____

List any previous medical diagnosis and treatment you have had for this condition.

_____

What do you think has caused or aggravates this condition?

_____

What is your general state of health? (Circle one) Excellent Good Fair Poor

When was the last time you really felt good? Weeks____ Months____ Years_____

Date of last Chiropractic treatment_____

Type of treatment_____

Time under care_____

Date of last physical exam?_____What prompted exam? _____

Date of last lab work?_____ Date of last x-ray? _____Body part? _____

Name: _____ Date: _____

Do you currently take any of the following? (Indicate how many and how long)

1. Vitamins/herbs/supplements _____
2. Birth Control _____
3. Over the counter drug _____
4. Pain med/muscle relaxant _____
5. Blood pressure medicine _____
6. Insulin _____
7. Laxative _____
8. Recreational drug _____
9. Prescribed medication _____
10. Other _____

To help us understand your total health, please provide information about your family members. Many conditions are the result of hereditary weakness.

Have you or your siblings, parents, or grandparents had any of the following?

Heart disease/Attack/circulatory problems _____

Kidney disease_____ Thyroid disease _____

Cancer _____ Autoimmune disease _____

Rheumatoid Arthritis _____ other arthritis _____

Cerebral vascular disease/stroke/TIA _____

Respiratory disease/Asthma/Emphysema/Chronic Bronchitis_____

Allergies_____ Scoliosis _____

Gastrointestinal disease, Crohns, ulcers, IBS _____

Diabetes _____ High Blood Pressure_____

Mental illness or social dysfunctions, ADD, ADHD, seizure or convulsions

_____

Name: _____ Date: _____

Do you use any of the following? Check if yes

Antihistamines_____ Alcohol_____

Tobacco_____ Coffee_____

Tea_____

If answered Yes to any of the previous explain here:

_____

_____

Type of Physical Activity	Frequency	Duration	Intensity

What is your greatest health concern?

_____

_____

_____

Are there secondary concerns you have?

_____

_____

_____

List four health goals.

1._____

2._____

3._____

4._____

Name: _____ Date: _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

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Advanced Therapeutic Wellness
Dr. Nam Nguyen D.C
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CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

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Chiropractic fees

Treatment	Cost
New patient assessment/Doctor's report/Initial treatment	$140
Follow-up treatment	$75
Extended treatment &/or 6 month reactivation	$100
Student new patient assessment/Doctor's report/Initial treatment	$110
Student follow-up treatment	$55

*Fees are HST exempt.

Insurance and Benefits Release:

I hereby authorize **Dr. Nguyen** to furnish my insurance carrier, benefits agent, attorney and any physician, any and all information regarding my health and treatment during any course of care. This includes copies of medical examination findings, x-ray reports, progress notes and my financial account.

As a CASH (Cash or Credit) patient I agree to pay at the time of service.
A copy of this authorization has the same validity as the original.

Patient Signature_____

Date_____

Effective March 17, 2021. Prices are subject to change without notice