truemotion® CHIROPRACTIC

262 Oxford St. E, Suite 108 · London, Ontario · N6A 1T8

T: (519) 963-1960 · F: (519) 963-1961 · www.tmchiro.com

CONFIDENTIAL PATIENT REGISTRATION

Date (DD/MM/YY):_________________ Name:____

Address:___________________________________ City:_________________ Province:______ Postal Code:____________

Date of Birth (DD/MM/YY):_______________________ Sex: M / F Age:________ Home Phone #: (_____)______–_______

Cell Phone # (_____)______–________ E-mail Address: ____

Emergency Contact:__________________________________ Relationship________________ Phone#: (_____)______–__________

PAST HEALTH HISTORY

O = Occasional **F = Frequent** **C = Constant**

O F C

☐ ☐ ☐ Arthritis / Joint pain
☐ ☐ ☐ Back pain / Stiffness
☐ ☐ ☐ Headache
☐ ☐ ☐ Allergy / Hives
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Depression
☐ ☐ ☐ Hearing problems
☐ ☐ ☐ Difficulty breathing
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Depression
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Dizziness / Fainting
☐ ☐ ☐ Blood pressure issues
☐ ☐ ☐ Vision problems
☐ ☐ ☐ Chest pain
☐ ☐ ☐ Asthma
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Abdominal pain
☐ ☐ ☐ Thyroid problems
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Nose bleeds

O F C

Pain or Numbness in

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Face
☐ ☐ ☐ Hands
☐ ☐ ☐ Neck
☐ ☐ ☐ Back
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet

Women only

☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excess menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Lumps in breast
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No
If yes, how many months?______

Check any of the following conditions you <u>currently have</u> or <u>have had</u>:

☐ Anemia / Bleeding Disorder
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Genetic disorder
☐ Heart disease
☐ Hepatitis
☐ HIV
☐ Influenza
☐ Measles or Mumps
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pneumonia
☐ Polio
☐ Psoriasis
☐ Stroke
☐ Tuberculosis
☐ Venereal Disease
☐ Other (describe):

____
____
____
____

Please describe any other symptoms or conditions you experience which are not listed:____

____

Please check your area(s) of complaint:
Neck ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Mid-Back ☐ Ribs ☐ Low Back ☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐
Other ☐ (*describe*):_____________________________________ Which side is bothering you? Right ☐ Left ☐ Both ☐
What was the initial cause? ____

How long have you had this condition? Is it getting worse? ☐ Yes ☐ No Is your condition constant? ☐ Yes ☐ No

Does it bother your (check appropriate box): ☐ Work? ☐ Sleep? ☐ Not Applicable ☐ Other (please specify)

Please circle the number that matches your *current* level of pain: No pain 1 2 3 4 5 6 7 8 9 10 Worst pain

Aggravating factors include: ☐ Sitting ☐ Standing ☐ Bending ☐ Walking ☐ Other (please specify)

Does anything decrease your pain or discomfort? ☐ Yes ☐ No If yes, what?

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, explain:

Have you ever had a concussion: ☐ Yes ☐ No If yes, how did it happen and date?

Have you ever been diagnosed or suspected of having cancer? ☐ Yes ☐ No If yes, type and date?

List current medications:

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ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. ______ I hereby authorize True Motion Chiropractic to provide Chiropractic Services for me.

2. ______ I understand and agree that *regardless of insurance coverage*, I am liable for any charges incurred as a result of services rendered to me at True Motion Chiropractic.

By signing this application I affirm that I have given true complete information.

Dated this _________day of _______________ 20_____.

____

Patient Signature

AUTHORIZATION TO TREAT A MINOR

If not applicable please disregard and leave blank

As a parent or legal guardian, I hereby authorize treatment for the following:

____ DOB (DD/MM/YY):______________________________

Patient's Full Name

to any chiropractic treatment deemed advisable , if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _______________ and expires _______________.

Signature_______________________________________ Witnessed by _____________________

(Parent or Guardian)

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TRUE MOTION CHIROPRACTIC FINANCIAL POLICY

1) We accept cash, debit, Visa and MasterCard.

2) All payments are <u>due at the time of service</u>, unless special arrangements have been agreed upon prior to visit.

3) If direct billing is available through your insurance company, you authorize us to submit any information required to receive reimbursement for services rendered. In the event that your insurance only covers a portion of the bill, you are responsible for payment of the remaining balance of your account.

4) If direct billing through your insurance company is not available, you are responsible for payment at the <u>time of service</u>. You will be provided with a receipt which you can deliver to your insurance company for reimbursement.

5) All supplements/vitamins, kinesiological taping, and other supplies <u>must</u> be paid for at the time they are received.

6) You are responsible for timely payment of your account.

<u>Missed Appointments</u>

7) We require <u>twenty-four (24) hours notice</u> for cancellation of all appointments, unless the cancellation is due to an emergency. There will be a **$30.00** charge to the patient for all appointments that are missed or not cancelled 24 hours or more prior to your scheduled appointment time.

I have read, understand, and agree with the above financial policy.

____ ___________________
Patient/Guardian Signature Date

<u>TREATMENT PAYMENT (Please Check Any That Apply):</u>

- o Self Funded (Paid by Cash or Own Means)
- o Private Health Care (Paid mostly by Extended Health Care)

<u>EXTENDED HEALTH CARE:</u> Company:____

Group / Plan Name:_____________________________ Group / Plan Number:_____________________________

Patient Signature Date