Your breakthrough to better health!
Clarity Wellness Chiropractic

Dr. Clarise Chan, B.Sc. (Hons), DC

File No. _____

NEW PATIENT INTAKE FORM

First Step:
Your Story
The Health Restoration System:

THE HEALTH RESTORATION SYSTEM

The Health Restoration System is a unique approach to achieving and maintaining optimal health.

Today in North America and the rest of the western world, the priority in health care is to help people after they are already sick. That backwards approach t o health care is why we are getting sicker and sicker. Recently a medical researcher stated it plainly, "We are not living longer we are dying longer." In other words, we have the capacity to keep people alive for longer and longer durations, but the majority of these people do not have a good quality of life. They cannot do most of the things that would allow them to live fulfilling lives.

Wouldn't it be great if we could work at staying healthy, instead of waiting to get sick? What if we could roll back the biological clock on the average person ? What if 50 really was the new 40? Or 60 was the new 50?

What if we could set up a system to allow you to do things at the age of 50, that you thought were impossible to do at the age of 40, or 30.

That is exactly what the Health Restoration System is designed to do. We are here to help you live longer and healthier, not die longer!!

How does the Health Restoration System work?

1. DISCOVERY – HEALTH DANGERS

Unique questions will lead to new answers.

We will begin by looking at the current state of your health and wellness. In essence, how are you doing right now? We will also ask you some detailed questions about your history and your family health history.

It is important to understand that your current health problem started years ago and was multi-factorial in origin. The only exception would be an acute trauma like a car accident or severe sports injury. Even with acute traumas the extent of the injuries is most often dependent on your health before the accident. Your answers to the following questions offer up clues to what dangers your body is currently encountering and will give us a base line for comparison to future outcomes.

2. THE DISEASE CAUSATION ANALYSIS

We will explore which lifestyle factors are affecting y our overall health and your ability to live fully alive. It is a well-known fact that 80 % of the risk factors for the two most feared killers; heart disease and cancer, are lifestyle related. The same is true for the majority of chronic illnesses affecting patients today.

Let's get started in understanding your problem and **find a solution**.

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DISCOVERY - HEALTH DANGERS

All patient information collected is protected by privacy legislation detailed in the Privacy Information Consent forms included with this new patient intake forms package.

CONTACT INFORMATION

Kindly write legibly if hand written to ensure accuracy of patient information

First Name: _____ Last Name: _____

Home #: _____ Work #: _____

E-mail: _____

Occassionally our Clinic may send out electronic newsletters and communication updates which you may unsubscribe from anytime, would you like to be added to the mailing list?

Yes please! ☐

No thank you ☐

Mailing Address: _____ Postal Code: _____

Town/City: _____ Province: _____

How did you hear about us/Referred by? _____

PERSONAL INFORMATION

Current Age: _____ Birth Date: Month: _____ Date: _____ Year: _____

Biological Sex: Male ☐ Female ☐

Relationship/Marital Status (please select): Single ☐ Common-Law ☐ Married ☐

Separated ☐ Divorced ☐ Widowed ☐

Spouse/Partner's Name (if applicable): _____

Children? (if applicable): Yes ☐ No ☐

If yes, how many? _____ How old are they? _____

If you are under the age of majority in Ontario, you will need authorized written parent/guardian authorization for chiropractic care at this clinic.

HEALTH HISTORY / PREVIOUS TRAUMAS

MOTORIZED VEHICLE ACCIDENTS

Are you consulting chiropractic care because of recent or any historical motor vehicle accidents? Yes ☐ No ☐

For each of the motorized vehicle incidents, please indicate boxes applicable:

		High Speed Collision (>40km/h?)	Whiplash Injury?	Vehicle Unrepairable?
Year: _____	Month: _____	☐	☐	☐
Year: _____	Month: _____	☐	☐	☐
Year: _____	Month: _____	☐	☐	☐

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DISCOVERY – HEALTH DANGERS

SPORTS & RECREATION

Sports Injuries: _____

_____

_____

DO YOU PARTICIPATE IN ANY OF THESE HIGH IMPACT ACTIVITIES? (please select all applicable):

Hockey ☐ Running ☐ Football ☐ Wrestling ☐ Mountain Biking ☐ Climbing ☐

Basketball ☐ Baseball ☐ Gymnastics/Weights ☐ Martial Arts ☐ Winter Sports ☐ Other _____

FALLS AND TRIPS

Falls from heights: _____ Falls down stairs: _____

Other falls: _____ Broken bones: _____

Childhood falls: _____ Home Injuries: _____

FALLS FROM ☐ Trees ☐ Roof/raised floor ☐ Play structure ☐ Bicycle Other: _____

OCCUPATIONAL STRESSORS

Are you consulting chiropractic care because of recent or any historical work place accident? Yes ☐ No ☐

Occupation: _____ Does your job regularly involve night shifts? _____

Tasks: sdfsdfsfsdfsfsdf woot woot lorum ipsum dolering lorum testing swer wefwvscsdf

Work Injuries: _____

My job requires (please select all applicable):

Heavy Lifting ☐ Mental Strain ☐ Extended Sitting ☐ Constant Standing ☐ Repetitive Stress ☐ Awkward Position ☐

POSTURES AND HABITS

Sitting > 6 hours daily ☐ Slouching ☐ Straining forward towards desk ☐ Constantly looking down at phone ☐ Stomach Sleeper ☐ Head Forward Posture ☐

Have your family, friends, colleagues, peers, or others comment about your posture? What do they say?

_____

_____

BIRTH TRAUMA

Was your own birth delivery any of the following (please select applicable)?

Difficult ☐ Forceps ☐ C-Section ☐ Epidural ☐ Suction ☐ Resuscitation ☐

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DISCOVERY – HEALTH DANGERS

What is your present health concern?

How long have you had this condition?

Have you had a similar condition in the past?

What activities aggravate your condition?

What relieves your condition?

Are you getting pain or numbness in your arms or legs?

Is your condition getting progressive worse?

- Yes it is getting worse ☐
- It's constant ☐
- It comes and goes ☐

The sensation of pain feels:

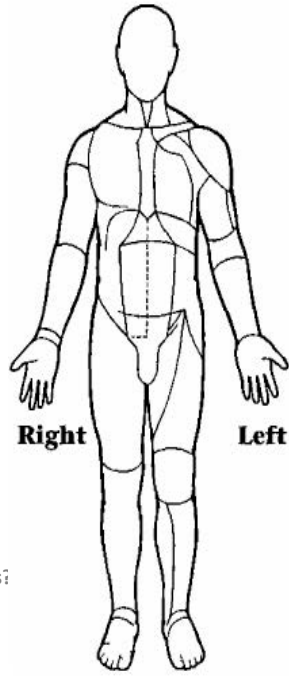
- Sharp ☐
- Burning ☐
- Throbbing ☐
- Dull ☐
- Tightness ☐
- Chronic ☐

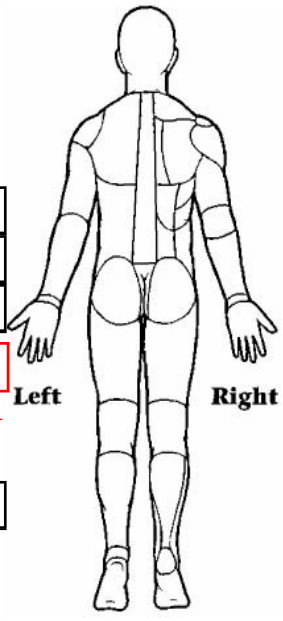
Pain Severity (0 --> no pain; **10 --> most severe**) ☐

___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___

How has this condition interfered with your daily life?

- Work ☐
- Home ☐
- Other _____
- Recreation/Hobbies ☐





If this form is printed, mark with an "X" on the diagrams of any past or present pain or problems; and/or check the appropriate areas below.

- Headaches ☐
- Vision Problems ☐
- Facial Pain ☐
- Hearing Problems ☐

Area	PAIN	NUMBNESS	TINGLING
SHOULDERS	☐	☐	☐
LEFT ARM	☐	☐	☐
RIGHT ARM	☐	☐	☐
LEFT HAND	☐	☐	☐
RIGHT HAND	☐	☐	☐
LEFT HIP	☐	☐	☐
RIGHT HIP	☐	☐	☐
LEFT KNEE	☐	☐	☐
RIGHT KNEE	☐	☐	☐
LEFT FOOT	☐	☐	☐
RIGHT FOOT	☐	☐	☐

Type of Sensation (Mark with "X")

	PAIN	NUMBNESS	TINGLING
NECK PAIN	☐	☐	☐
UPPER BACK PAIN	☐	☐	☐
SHOULDER BLADES	☐	☐	☐
MIDDLE BACK PAIN	☐	☐	☐
LOW BACK PAIN	☐	☐	☐
SACROILIAC/TAILBONE	☐	☐	☐
GLUTES	☐	☐	☐
LEFT HAMSTRING	☐	☐	☐
RIGHT HAMSTRING	☐	☐	☐
CALVES	☐	☐	☐
LEFT HEEL	☐	☐	☐
RIGHT HEEL	☐	☐	☐

Family Health Problems?

Other Health Problems?

DISCOVERY – HEALTH DANGERS

Please check with an "X" any of the following signs of Organ Malfunction or Disease you have experienced with associated body area below:

COGNITIVE / SINUS SYSTEM

- ☐ Blurred / Failing Vision
- ☐ Deafness / Ringing In Ears
- ☐ Ear-Aches
- ☐ Sore Throat / Tonsilitis
- ☐ Thyroid Problems
- ☐ Sinus Problems

CARDIOVASCULAR SYSTEM

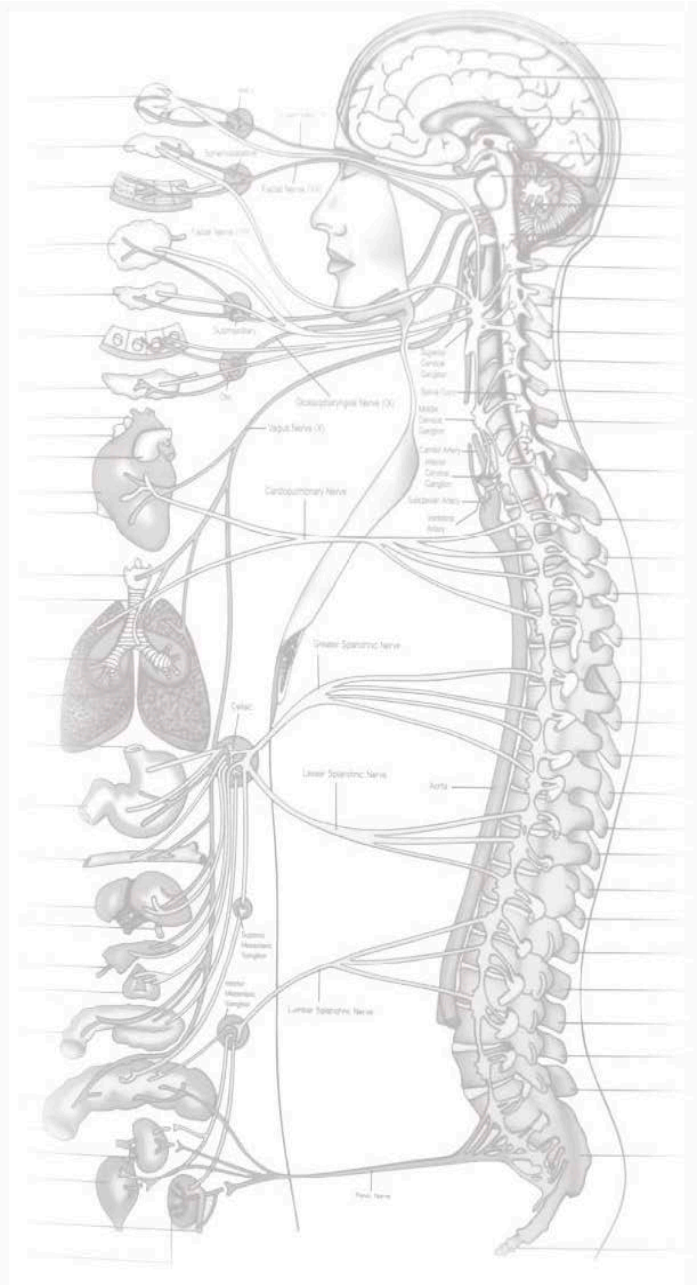
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Heart Medication
- ☐ High Blood Pressure Medication

RESPIRATORY SYSTEM

- ☐ Frequent Bronchitis
- ☐ History of Pneumonia
- ☐ Chronic Cough
- ☐ Spitting up Phlegm / Blood
- ☐ Difficulty Breathing
- ☐ Tuberculosis

DIGESTIVE SYSTEM

- ☐ Heart Burn/ Indigestion
- ☐ Stomach Cramps
- ☐ Constipation
- ☐ Food Allergies
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Ulcers
- ☐ Belching / Gas
- ☐ Nausea / Vomiting
- ☐ Liver / Gall Bladder
- ☐ Colon Trouble
- ☐ Black / Blood Stool



GENERAL SYMPTOMS

- ☐ Fever Chills / Sweats
- ☐ Frequent Colds
- ☐ Fainting / Dizziness
- ☐ Seizures

- ☐ Headaches / Migraine
- ☐ Neck pain / Stiffness
- ☐ Tension across Left/Right Shoulders
- ☐ Mid-back pain / Stiffness
- ☐ Numbness / Tingling in Hands/Arms
- ☐ Skin Problems
- ☐ Tremors
- ☐ Loss of Balance
- ☐ Unexplained Weight Loss / Gain
- ☐ Anemia
- ☐ Alcoholism
- ☐ AIDS/HIV
- ☐ Loss of Sleep
- ☐ Poor Memory / Concentration
- ☐ Learning Disability
- ☐ Irritable / Nervousness / Tension
- ☐ Depression / Emotional Problems
- ☐ Decreased Energy / Fatigue
- ☐ Tired / Lethargic
- ☐ Autoimmune Diesease
- ☐ Antibiotic Use
- ☐ Cancer: _____
- ☐ Allergies / Asthma
- ☐ Scoliosis / Spinal Curvature
- ☐ Low Back Pain / Stiffness
- ☐ Faulty Posture
- ☐ Painful Tailbone
- ☐ Foot Trouble (Left / Right)

MUSCULOSKELETAL SYSTEM

- ☐ Painful Joints
- ☐ Painful Muscles
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis

FEMALES ONLY

- ☐ Painful Menstruation
- ☐ Cramps or Backaches
- ☐ Passed Menopause
- ☐ Excessive / Irregular Flow
- ☐ Abnormal Discharge

Date of Last Menstrual Period _____

Currently Pregnant? ☐ Yes ☐ No

If yes, how many weeks? _____

Other Comments / Concerns _____

History of Miscarriage? ☐ Yes ☐ No

DISCOVERY – HEALTH DANGERS

PERSONAL QUALITY OF LIFE QUESTIONNAIRE

How has your condition affected your quality of life?_____

_____

How has your condition affected you emotionally? _____

_____

How has your condition affected your family life and/or relationship? _____

_____

If left uncorrected, how do you see your condition affecting your life over the next 1-5 years? _____

_____

If you are a candidate for spinal reconstruction and if we were having this conversation 12 months from today, what has to happen over that time to make you feel happy with your progress?

_____

What is your greatest motivation (other than pain) for seeking out a solution for your condition?
(Mobility, quality of life, family, participation in sports, etc.)

_____

_____

Do you believe that this condition can improve? _____

_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I understand that any insurance coverage is an arrangement between the insurance company and myself. I understand that the Chiropractor will prepare any necessary reports and forms to assist me in submitting a claim to the insurance company. Furthermore, I understand and agree that all services rendered, are **charged directly to me and that I am personally responsible for payment.**

Our goal is to locate and correct vertebral subluxation, thereby restoring normal function to the spine, and removing any interference to nerve function, and maximizing the transmission of nerve impulses from brain to body. While we often see dramatic improvements in many diseases and conditions by restoring function to the spine and removing nerve interference, Chiropractic is not a treatment of any disease condition.

I understand and I am informed that, as in all health care, in the practice of Chiropractic there are some possible risks to care including, but not limited to, minor strains and sprains, and disc injuries. Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following – there have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes, or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are less than 1 in 5.8 million. Tests with or without X-Rays have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest, most effective forms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor.

I have read and understand the above statements and consent with agreement to treatment.

Name (Printed): _____ **Date:** _____

Signature: _____

Name of Guardian (Printed): _____ **Date:** _____

Signature: _____

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DISEASE CAUSATION ANALYSIS

EXERCISE

Do you participate in aerobic exercise at least 30 minutes per day?

- ☐ 0 days / week
- ☐ 1 - 2 days / week
- ☐ 3 - 4 days / week
- ☐ 5 - 7 days / week

Do you lift weights or do resistance training?

- ☐ Cross Fit
- ☐ Gym Membership
- ☐ P90x
- ☐ Rowing
- ☐ Other _____

What activities are you involved in that require balance, if any?

_____

How often do you stretch per week?

- ☐ 0 days / week
- ☐ 1 - 2 days / week
- ☐ 3 - 4 days / week
- ☐ 5 - 7 days / week

CHEMICAL STRESSORS: NUTRITION

Do you feel that you make healthy food choices?

☐ Yes ☐ No ☐ Not Sure

Do you have high intake of fruits and vegetables?

☐ Yes ☐ No ☐ Not Sure

Do you have a high intake of lean meat for protein?

☐ Yes ☐ No ☐ Not Sure

Are you at your ideal body weight?

☐ Yes ☐ No ☐ Not Sure

CHEMICAL STRESSORS: TOXIC LOAD

Do you presently, or have in the past:

- ☐ Smoke?
- ☐ Carry Excessive Weight?
- ☐ Consume Alcohol?
- ☐ Take Recreational Drugs?

EMOTIONAL STRESSORS

Are you currently experiencing, or have you experienced significant stress in the following areas?

- ☐ Marriage _____
- ☐ Kids _____
- ☐ Finances _____
- ☐ Work _____
- ☐ Elderly Parents _____
- ☐ Major Life Event (Births/Deaths) _____

MEDICATIONS

For what condition(s)?

_____
_____
_____
_____
_____
_____

FAMILY HEALTH HISTORY

What significant health concerns have your family members experienced?

Parents/Siblings _____

Spouse/Partner _____

Children (1) _____

Children (2) _____

SURGERIES

For what condition(s)?	Year?

Any other details that may assist the Doctor in understanding your lifestyle and health status:

_____
_____
_____

WHAT YOU CAN EXPECT NOW

YOUR FIRST VISIT

Today we have started a discovery process with you to determine the source of your health concerns.

THIS HAS INCLUDED:

1. DISCOVERY – HEALTH DANGERS questionnaire.
2. A DISEASE CAUSATION analysis

NEXT WE WILL GO THROUGH:

3. A detailed HEALTH HISTORY with one of our exam specialists.
4. A CRITICAL BLOCK Analysis:

   A thorough SPINAL EXAMINATION by your doctor, to determine any abnormal alignment and motion patterns, and how this is detrimentally affecting the central and peripheral nerve systems and organ function (subluxation).

5. ANY FURTHER IMAGING STUDIES that may be necessary such as X-Rays.

YOUR NEXT APPOINTMENT:

After the examination, your doctor will determine if you have critical blocks to healing caused by abnormal alignment or abnormal motion of your spine (subluxations) and if you are a good candidate for reconstructive or structural Chiropractic care. Your doctor will then arrange for your next visit, which is the Doctor's Report. The purpose of the Doctor's Report is to review with you the findings from your consultation and examination.

At the Doctor's Report, the doctor will give a detailed overview of how reconstructive structural Chiropractic care works and the scientific evidence supporting the specialized work that we do. The doctor will also review the Health Restoration System action plan. This will be done in a small group setting with other new patients.

We know that there is tremendous power in you fully understanding your problem and how we will work with you to correct it. That is why the Doctor's Report is detailed and very informative.

We ask that your spouse or partner comes to the Doctor's Report with you. Health information is complex and it can be difficult to explain your results and the Health Restoration System action plan to your spouse or partner if they are not present at the report. Having support and understanding at home is important to your complete recovery.

After the presentation, your doctor will privately review the results of your examination and X-Rays. Your doctor will o utline a course of care, discussing how long it will take to correct your spine, how often you will come in for your adjust ments, and the financial investment for your care and correction. At that point you will be able to decide how you would like to proceed.

YOU ARE IN GOOD HANDS. YOUR HEALTH IS OUR #1 PRIORITY.

Thank you for giving us the privilege to determine if we can help you become fully alive.

Clarity Wellness Chiropractic

Dr. Clarise Chan

4-36 Park Lawn Road | 905-990-5000

PRIVACY INFORMATION CONSENT

Clarity Wellness Chiropractic has always taken our patients' confidentiality seriously. We understand that you entrust us with your personal and medical information. We are committed to take all necessary measures to safeguard this information.

Our privacy policy fully complies with the federal government's Personal Information Protection & Electronic Documents Act (PIPEDA), which sets out guidelines for the collection, use, and disclosure of personal information.

This consent form outlines what we do to ensure that:

* Only necessary information is collected about you;
* We only share your information with your consent;
* Storage, retention, and destruction of your personal information complies with existing legislation and privacy protocols.

Our office will collect, use and disclose information about you for the following purposes:

* To deliver safe and efficient patient care;
* To identify and to ensure continuous high quality service;
* To assess your health needs and provide care;
* To establish & maintain communication with you;
* To advise you of your treatment options;
* To communicate with other treating health-care providers;
* For teaching & demonstrating purposes on an anonymous basis;
* To process, invoice, and collect payments for goods & services;
* To complete and submit forms for third party adjudication and payment;
* To comply with legal and regulatory requirements including delivery of patient charts/records to governing bodies according to the provisions of the Regulated Health Professions Act/Health Professions Appeal and Review Board;
* To permit potential purchasers, practiced brokers, or advisors to evaluate Practice
* To deliver your charts and records to the office's insurance carrier to enable them to assess liability and quantify damages, if any

Our office will not supply our insurer with confidential medical history. In the event such a request is made, we will notify you. You will also be notified should any other unusual or inappropriate requests be received.

Please read other side….

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PRIVACY INFORMATION CONSENT (CONTINUED)

By signing this consent form, you agree that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes listed. If a new purpose arises, we will seek your approval in advance. You may withdraw your consent at any time. We will explain the ramifications of that decision and process.

I have reviewed the above document that explains how this office will use my personal information and how it will be protected.

I have been informed that the office has a Privacy Code and that I can view it at any time.

I agree that the doctors, and staff of Clarity Wellness Chiropractic may collect, use and disclose personal information as outlined in this document in accordance with the Personal Information Protection and Electronic Documents Act (PIPEDA).

Print Name	Signature/Guardian Signature
Date	Signature of Witness

If you have any questions or concerns regarding our Privacy Policy or our collection use or disclosure of your personal information, please discuss them with or notify us by writing to:

Privacy Officer
Clarity Wellness Chiropractic
36 Park Lawn Road Unit 4
Etobicoke, Ontario M8V 0E5

We appreciate your confidence in us.