

## Dr. Rebecca Patterson, D.C.

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### Patient Information

Name: \_\_\_\_\_ Date of Birth: mm/dd/yyyy \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
May we leave you a message at either number? (please circle)      YES      NO  
Email: \_\_\_\_\_  
How did you find out about us? \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Emergency Contact: (Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_ (Phone number) \_\_\_\_\_

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### Billing Information

**Is your complaint related to a motor vehicle accident? (Please circle)**      Yes      No

*If Yes, please fill in the following:*

Date of accident: \_\_\_\_\_ Insurance company: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_

Insurer's address: \_\_\_\_\_

Insurer's phone: \_\_\_\_\_ Insurer's Fax: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

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### Fee Schedule

Initial Assessment: \$80      15 minute follow-up: \$40      30 minute follow-up: \$65      Acupuncture: \$65

Radiology Reading and follow up: \$65

Payment is due at the time services are rendered.

We require 24 hours notice if you are unable to make your scheduled appointment. Routinely missed appointments without advanced notice will be billed at the regular fee.

A 50% deposit is required prior to ordering custom-made orthotics.

I have read and understand the financial policy. I agree to pay any and all charges incurred for services rendered and/or items purchased at Natural Care Clinic.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Health History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Previous Chiropractor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please list all current medical diagnoses:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all current medications and supplements:  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been hospitalized? (please circle) YES NO  
 If yes, please describe: \_\_\_\_\_

Please list and date any previous traumas or fractures:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any other current treatments or therapies  
 \_\_\_\_\_

**For Women Only:**

Age of onset of Menstruation: \_\_\_\_\_ Date of last cycle \_\_\_\_\_ Length of cycle: \_\_\_\_\_

Are you Pregnant or Breastfeeding? (please circle) YES NO

Please list any gynecological diagnoses or concerns: \_\_\_\_\_

Number of children: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_

Please circle all that apply:

D&C	Hysterectomy	Caesarian section	
Breast pain	Breast lumps	Nipple Discharge	

**For Men Only:**

Do you wake in the night to urinate? (please circle) YES NO Number of times: \_\_\_\_\_

Please circle all that apply:

Weak stream	Incomplete bladder emptying	Blood in Urine	testicular pain or swelling
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**Additional Concerns: (please circle all that apply at present or in the past)**

- |                |                    |                    |                    |                    |               |   |
|----------------|--------------------|--------------------|--------------------|--------------------|---------------|---|
| Headaches      | Cough              | Heartburn          | Seizures           | Hay fever          | Cancer        | Joint pain / redness / Swelling / Stiffness |
| Dizziness      | Blood in Sputum    | Nausea             | Weakness           | Allergies          | Heart disease |   |
| Fainting       | Trouble Breathing  | Constipation       | Paralysis          | Hives              | Diabetes      | Arthritis                                   |
| Double vision  | Asthma             | Diarrhea           | Numbness           | Rashes             | HIV           |   |
| Blurred vision | Bronchitis         | Hemorrhoids        | Pins/needles       | Skin itching       | Tuberculosis  |   |
| Tinnitus       | Pneumonia          | Urinary Infections |                    | Skin lumps         |               | Fever                                       |
| Vertigo        | Heart trouble      | Kidney stones      | Bruise easily      | Dry skin           | Anxiety       | Weight change                               |
| Sinus trouble  | Chest pain         | Bloating/gas       | Anemia             | Sores              | Depression    | Fatigue                                     |
|                | Heart Palpitations | Liver              | Thyroid trouble    | Hair/ Nail changes | Bipolar       | Malaise                                     |
|                | Hypertension       | Gallbladder        | Excessive sweating |                    |               |   |
|                |                    | Jaundice           |                    |                    |               |   |

## Dr. Rebecca Patterson, D.C.

### Privacy Policy

Dr. Rebecca Patterson and Natural Care Clinic must collect, use and disclose some personal information in the process of conducting commercial activities. The following document outlines the terms of collection, use and disclosure of personal information.

Personal information is information about an identifiable individual. We collect information such as: your name, contact information, age, gender, marital status and occasionally insurance information. Within our patient file we collect information pertaining to your health including: Health history, measurements, examination results, health conditions, medical diagnoses, health services provided to you, health information obtained in the course of providing treatment to you, your prognosis and other opinions formed during assessment and treatment, information pertaining to your compliance with treatment and assessment, reasons for your discharge and recommendations made to you.

This information is collected, used and disclosed for the purpose of providing you with safe and effective health care, to assess your health care needs, to advise you of your treatment options, to enable us to contact you, to communicate with other treating health care providers, to allow us to follow up for treatment and billing, to collect payment from third parties and to comply with the regulatory requirements of the College of Chiropractors of Ontario's (CCO) Peer Review Program which assures the protection of the public through the assessment and maintenance of core knowledge, competencies and skills of the members of the CCO, and to comply with the standards set out by the CCO, the PIPEDA Act (2000) and the PHIPA Act (2004).

Further consent must be obtained prior to the disclosure of personal information for other than the intended use above except in cases where there is legal authority to disclose personal information without consent.

Natural Care Clinic safeguards your personal information. At times, staff members of Natural care clinic including administration and other therapists, may come in contact with your personal information. All staff members are informed of the sensitive nature of patient files and act according to our policy regarding the use and protection of your personal information. Occasionally, authorized members of the CCO may review your file as part of the Peer Review Program.

You have the right to access your personal information. If copies are required they will be provided at a minimal cost.

#### Consent:

I understand that to provide me with Chiropractic goods and services, Natural Care clinic will collect some personal information about me. I have reviewed Natural Care Clinic's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction. I agree to Natural Care Clinic collecting, using and disclosing personal information about me as set out above and in the Natural Care Clinic Privacy Policy.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Witness)

## Dr. Rebecca Patterson, D.C.

### Informed Consent to Chiropractic Treatment

There are risks and potential risks associated with manual therapy techniques used by doctors of chiropractic. In particular, you should note:

- a) While rare, some patients may experience short-term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur as a result of certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment although no scientific evidence has demonstrated such injuries are caused, or may be caused by spinal adjustments or other chiropractic treatment.
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general (including spinal adjustment) the options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor, including any recommended spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Name: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_

Witness: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_

### Informed consent to Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including moxibustion, cupping, and/or electroacupuncture by the above named doctor or any duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding of bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment, which the doctor feels at the time, based upon the facts then known is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-mentioned acupuncture procedures(s). I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

#### **N.B Female patients:**

**I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.**

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Name: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_

Witness: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_