Welcome To Our Office

Outline of Procedures for New Patients:

Step 1

All new patients are requested to fill out a confidential "Patient Health Record".

Step 2

Your first "Consultation" with the doctor to discuss your health problems.

Step 3

You will receive a "Chiropractic Examination" to determine if chiropractic care is appropriate for you.

Step 4

An in-depth, technologically-advanced assessment of your nerve and energy system to determine how well your brain is communicating with your body. Any interference to this communication may be measured by a digital posture exam to study effects on your posture over your life span.

Step 5

You will be advised as to a time you can attend a New Patient Health Workshop for Dr. Fryday's InsideOut Lifestyle Plan. Our records show that those patients who respond most rapidly to care are those who have learned to help themselves. We give you the opportunity to learn what you can do to optimize your health, quickly and cost effectively. You will also learn how to stay healthy, feel free to bring your family and friends. Please advise front desk as to how many people will attend.

Step 6

You will be advised as to a time you can return for your "ROF" (Report of Findings) when Dr. Fryday will inform you as to your examination results and whether or not you are a candidate for chiropractic care. During your ROF, your recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

Step 7

Chiropractic care will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained. At that point you will be advised as to how often you should come in for adjustments to maintain your wellness.

Step 8

We strive to educate our patients with the latest health and wellness information by routinely emailing health tips and items of interest. You may unsubscribe from this service at any point but we encourage you to check it out. Please indicate below if you are willing to receive emails from our wellness centre.

☐ Yes please send health info. to my email address listed on the next page ☐ No thank you

To save time and allow us to better serve you, please complete all questions on the next pages. Thank you

Personal History

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Cell: _____ Email: _____
Birthdate: _____ Age: _____ Sex: ____ M ☐ F ☐
Height: _____ Weight: _____
Business/Employer: _____ Business Phone: _____
Type of Work: _____
Circle One: Married Single Widowed Divorced Separated Other Number of Children: _____
Emergency Contact: _____ Phone Number: _____ Relationship: _____
Who may we thank for referring you to this office? _____

Current Health Condition

Current Complaint(s): _____
Other doctors seen for this condition? ☐ Yes ☐ No Who? _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has the condition occurred before? ☐ Yes ☐ No
Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: _____
Date of Accident: _____ Time of Accident: _____
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _____
What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent
Please describe how it feels when this problem is at its worse: _____
_____
Place an X on the grade to indicate the severity of your pain:
LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*
Compare this problem at its worst and a time when you feel great. How does this problem interfere with:
Your ability to work? _____
Your ability to enjoy your family or your social time? _____
Your ability to enjoy your hobbies or sports? _____
At its worst, how old does this problem make you feel? _____
If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No
Drugs you take now: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Other: _____
Do you suffer from any other condition than the one you are now consulting us for? _____
_____
On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____
Have you had X-rays taken in the last six months? ☐ Yes ☐ No If yes, where? _____

Past Health History

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other: _____

Previous: Childhood Traumas ☐ _____ Sports Injuries ☐ _____
Motor Vehicle Accidents ☐ _____ Work Injuries ☐ _____

Hospitalization (other than above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name: _____
Approximate Date of Last Visit: _____

Family Health History

Name of Family Physician: _____

Please indicate any health issues that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? _____

Have your children ever had a spinal check-up? ☐ No ☐ Yes ☐ If yes, where and when? _____

_____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.
Check any of the following you have had in the past six months:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Gas/Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black/Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

Male / Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

Stress Evaluation

Patient: _____ Date: _____

When in your life did you experience any of the stresses listed below: C (child), T (teenager), A (adult), N (not at all)

I. PHYSICAL STRESS:

					Explain
Birth Trauma	C	T	A	N	
Slips/Falls	C	T	A	N	
Sports Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying Heavy Objects	C	T	A	N	
Repetitive Lifting/Bending	C	T	A	N	
Continuous Sitting/Standing	C	T	A	N	
Bone Fracture/Surgery	C	T	A	N	
Driving For Many Hours	C	T	A	N	
Car Accidents (How many? ____)	C	T	A	N	
Physical Abuse	C	T	A	N	
Work Injuries (How many? ____)	C	T	A	N	
Sleeping Position/Stomach	C	T	A	N	

II. CHEMICAL STRESS:

					Explain
Smoker – Amount? _____	C	T	A	N	
Second-Hand Smoke	C	T	A	N	
Poor Diet	C	T	A	N	
Caffeine – Amount? _____	C	T	A	N	
Excessive Sugar	C	T	A	N	
Artificial Sweeteners	C	T	A	N	
Prescription Drugs	C	T	A	N	
Over-The-Counter Drugs (Tylenol, Advil, etc.)	C	T	A	N	
Environmental Pollution (Air, Water, etc.)	C	T	A	N	

III. EMOTIONAL STRESS:

					Explain
Relationships	C	T	A	N	
Career	C	T	A	N	
Children	C	T	A	N	
Money	C	T	A	N	
Fast-Paced Life	C	T	A	N	
Internalized Feelings	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Sickness or Loss of a Loved One	C	T	A	N	
Quick Temper	C	T	A	N	
Verbal Abuse	C	T	A	N	

IV. **WHICH DO YOU FEEL IS YOUR PRIMARY STRESS?** ☐ PHYSICAL ☐ CHEMICAL OR ☐ EMOTIONAL?

Explain: _____

Females Only

When was your last period?

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

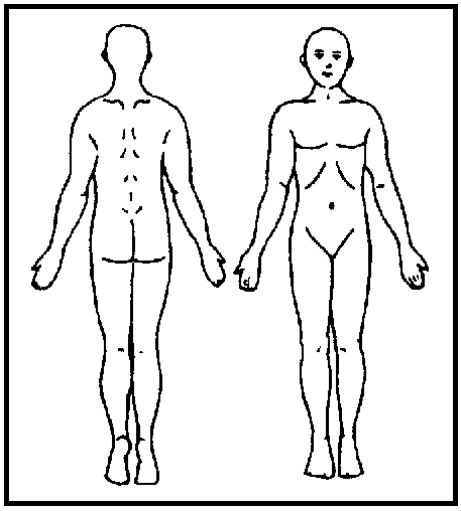
- ☐ Yes
- ☐ No

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little

Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema



Please outline on the diagram the area of your discomfort and any radiation of pain.

Please list any questions or concerns below:

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care/InsideOut Lifestyle). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐ Preventative Care/InsideOut Lifestyle – Life Enhancement and Wellness Care
- ☐ Corrective Care – Removing Cause and Remodeling Soft Tissue
- ☐ Relief Care – Band-Aid Care Only
- ☐ Check here if you want the doctor to select the type of care appropriate for your condition.

Please Read Carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and / or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic / staff member and / or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, rib fractures, and disc injuries. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

_____ _____

Patient Signature Date

Financial Policies and Options

Financial Policy for Corrective Care

It is our policy that you pay for services at the time you receive them unless other arrangements are made in advance. If you have an insurance policy that covers chiropractic, we will give you receipts for you to file with your insurance company so that you can be reimbursed for your Corrective Care in a timely manner. Should your Insurance company need information or reports from our office to expedite your reimbursement, please inform our staff and we will provide them with whatever they need. Depending on the depth of the report, there may be a small processing fee associated with the report.

The following financial options are available for you to choose from while you are under Corrective Care. As long as you keep your agreement with us, it does not matter to us which one you choose. It is important, however, that you choose a plan that will allow you to finish what you start.

It has been our experience that since you will be coming in frequently for your visits during the initial Corrective Care, you will simplify your record keeping significantly, and make your daily visits much quicker and more efficient, if you choose one of our prepayment plans. If you choose one of these plans, you will not have to stop at the front desk each visit to handle your account, you will not have to write a lot of cheques, and your insurance filing will be much simpler. If you have any questions about these plans, we will be happy to discuss them with you.

Financial Options for Corrective Care

Please check the following method of payment that appeals to you most:

____ I choose to prepay for my entire Corrective Care in the beginning to receive a 15% bookkeeping savings and remove my financial obligations immediately. I understand that should I need to discontinue my care for any reason, I will be reimbursed for the unused portion of my credit balance.

____ I choose to prepay for my visits monthly by leaving post-dated cheques or my credit card on file.

____ I choose to pay for my care on a visit to visit basis even though it may slow down my visits and make record keeping more tedious.

____ My income level is below that poverty level and I would like to find out if I qualify as a hardship case and discuss alternative arrangements if possible.

____ I would like to find out about your family discounts so I can start my family on Chiropractic care right away.