Petrolia Chiropractic Centre

PATIENT INFORMATION Date:_____

The following is a confidential questionnaire that will help us determine the best possible course of treatment for you. Please complete as accurately as possible. Thank you!

Personal Information

Name: _____
Address: _____
City: _____ Province: _____Postal Code: _____
Date of Birth (D/M/Y): _____Age:_____ Gender: M□ F□

Contact Numbers

Home: (___) _____ Cell:(___)_____
Business: (___) _____Email Address (optional):_____

Health Insurance

***Alberta Health Care Number: _____**
***Extended Health Care Company _____**
***Plan Id #_____Group#_____**

In Case of Emergency Contact: _____Phone number:_____
Employment: □Full time □Part Time □Unemployed Last day worked:_____
Employer: _____ Occupation: _____
Medical Doctor:_____ Phone Number:_____

Referral:

□Personal _____ □Phone book
□Doctor_____ □Sign
□Physiotherapist_____ □Other _____
□ Massage Therapist _____

Prior Chiropractic Care: Name_____
Results_____
(0=poor, 5=average, 10= excellent)

Motor Vehicle Accident

Is this visit the result of a motor vehicle accident? □Yes □No **(if no, skip to WCB section)**
If yes, date of accident?_____
If yes, is your insurance company aware? □Yes □No
If yes, have you completed an AB-1 form? □Yes □No
If yes, have you received previous treatment for this accident? □ Yes □ No

WCB

Is this visit the result of a work injury? □Yes □No **(if no, skip to Current Health)**
If yes, Date of Injury? _____Is your employer aware? □Yes □No
Any previous WCB claims □ Yes □ No
When?_____ Injured Area?:_____

Current Health Condition

Purpose for this appointment_____
(ie major complaint)
Explain how this occurred:_____
When did this condition begin?(DD/MM/YYYY) _____
Condition has persisted for: □Days □Weeks □Months □Years
Other injuries_____
Symptoms □Came on suddenly OR □Come and go
Symptoms are WORSE in: □AM □Midday □PM □Constant
What activities make your condition better?_____
What activities make your condition worse?_____
Have you ever had this condition before? □No □Yes,
When_____
Other doctors seen for this condition:_____

Accidents/Injuries/Surgeries/Hospitalizations

Please list any accidents, injuries surgeries or hospitalizations you have had. (If there's several please list most recent, relevant.

_____Date/Age_____
_____Date/Age_____
_____Date/Age_____
_____Date/Age_____

Date of your last spinal x-rays, CT bone scan or MRI:_____
Where?_____

Past Health History

Check any of the following conditions you have had:

MUSCULO-SKLETAL
- □Low Back Pain
- □Pain Between Shoulders
- □Neck Pain
- □Arm Pain
- □Joint Pain/Stiffness
- □Walking Problems
- □Difficulty Chewing/Clicking Jaw

GENERAL
- □Fatigue
- □Allergies
- □Loss of Sleep
- □Headaches
- □Fever
- □Prostate/Sexual Dysfunction

EYE/EAR/NOSE/THROAT
- □Vision Problems
- □Sore Throat
- □Stuffed Nose and Sinuses
- □Hearing Difficulty
- □Ear Aches

GENITO-URINARY
- □Bladder Troubles
- □Painful Urination
- □Excessive Urination

DIGESTIVE TRACT
- □Heartburn
- □Gas/Bloating after meals
- □Constipation
- □Diarrhea
- □Bowel Infection
- □Weight Trouble

FEMALE

Are you or could you be pregnant? □Yes □No

If yes, date of last cycle_____

Due Date_____

- □ Menstrual Cramping
- □ Breast Pain/Lumps

DIGESTIVE TRACT
- □Heartburn
- □Gas/Bloating after meals
- □Constipation
- □Diarrhea
- □Bowel Infection
- □Weight Trouble

CARDIOVASCULAR
- □Blood Pressure Problems
- □Heart Problems
- □Lung Problems
- □Stroke
- □Chest Pain

NERVOUS SYSTEM
- □Nervous
- □Numbness
- □Dizziness
- □Forgetfulness
- □Confusion/Depression
- □Fainting
- □Convulsion
- □Cold/Tingling Extremities
- □Stress

Family Health History

Do you or other family members have a history of any of the following?

Arthritis	□Self	Family Member_____
Asthma	□Self	Family Member_____
Cancer	□Self	Family Member_____
Diabetes	□Self	Family Member_____
Heart Disease	□Self	Family Member_____
Hypertension	□Self	Family Member_____
Hypoglycemia	□Self	Family Member_____
Kidney Disease	□Self	Family Member_____
Depression	□Self	Family Member_____
Mental Illness	□Self	Family Member_____

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Lifestyle

Do you Smoke? □Yes □ No How Much?_____
Do you drink Alcohol? □Yes □ No How Much?_____
Do you drink coffee/tea? □Yes □ No How Much?_____
Do you exercise? □Never □1-2Days a week □3-5Days a week □Daily
Duration of exercise: □10min. □10-20min. □ 20-30min □30-60min. □60+min.
Intensity of activity_____
(0=no sweating or increase heart rate, 10=sweating and rapid heart rate)
Please rate your level of fitness:_____
(0=poor, 5=average, 10=excellent)

Do you have any Allergies? □Yes □No
What?_____

Please list medications/vitamins/herbs you take:
_____Reason_____
_____Reason_____
_____Reason_____
_____Reason_____
_____Reason_____

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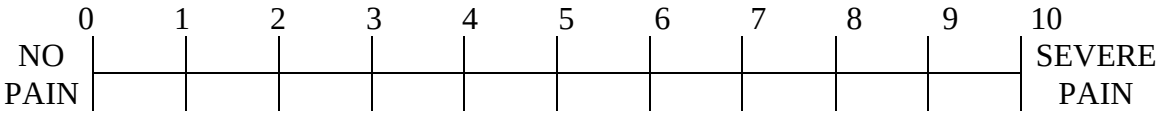
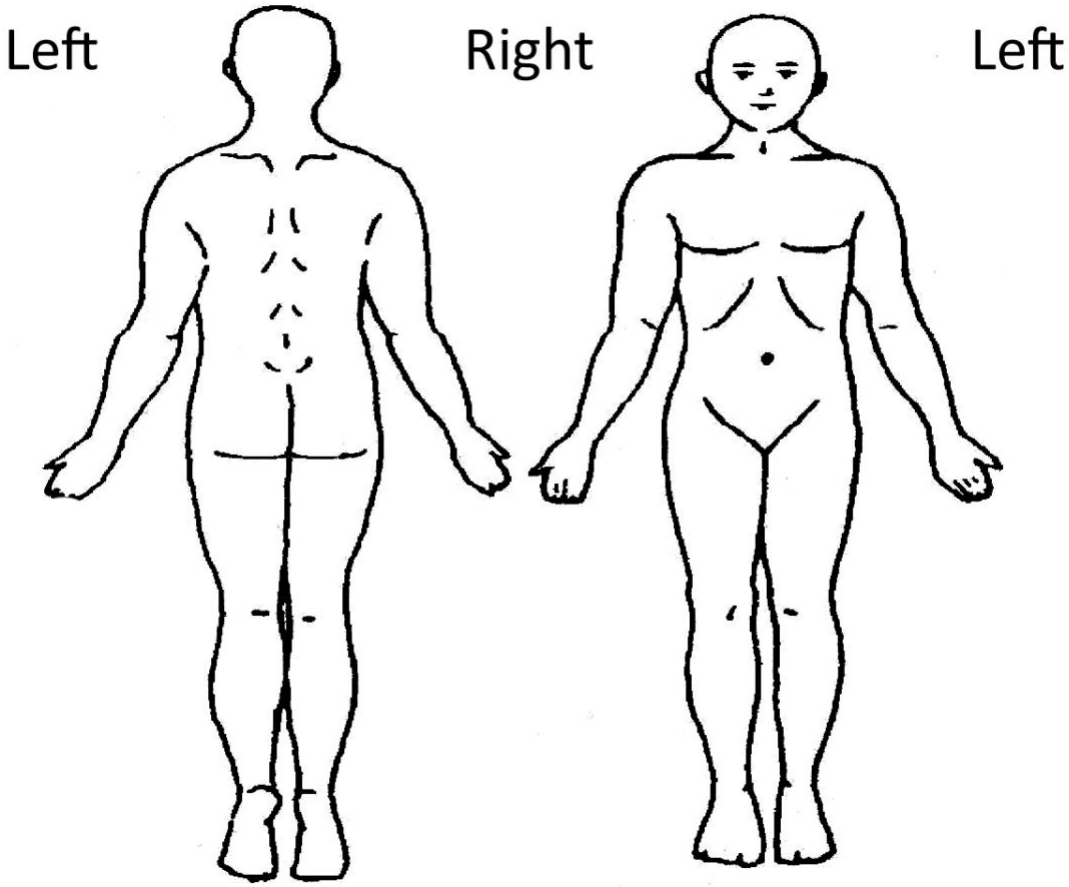
PAIN DIAGRAM

Using the line scale below, rate the <u>most common</u> intensity of pain since onset



On the diagram below, mark the areas on your body where you feel the described sensations. Use the appropriate symbol for the type of pain. Include **ALL** affected areas.

Pain symbols:	ACHE	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING
	\\\	+++	ooo	bbb	sss



Benefit Assignment Form

Instructions: This form must be filled out when claim payment is assigned to the Provider. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

_____ _____
Date: Signature

Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:
use my personal information for the above purposes.

exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.

exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.

exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Electronic Transmission Authorization and Consent Form

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

_____ _____

Date: Signature