MACKENZIE CHIROPRACTIC ASSOCIATES
Sharing Your Care For Quality of Life, SINCE 1973

Patient Introduction Form & Clinical Record (please print)

NAME:____ Marital Status: S M W D
(Last) (First) (Middle)

Date of Birth (MM/DD/YYYY):_________________ Mobile Phone: _______________
Street Address_____________________________ Home Phone:________________
City/Town__________________________________ Work Phone:_________________
Postal Code_____________
Occupation/Profession______________________Email_______________________________
Employer_________________________________ Spouse's Name__________________
Number of Children_________ Referred to this office by________________________
Have you had chiropractic care before?_______ By Whom?_________________
Last Visit?__________
Do you have any reason to believe you may be pregnant?______ Due Date_____________
Are you claiming under WorkSafe? No__ Yes__ Claim #_____________________________
Are you claiming under ICBC? No__ Yes__ Claim #
____
Briefly describe complaint
____
____
____
____
Do you have difficulty with any of the following? If yes, mark "X":

( )headaches ( )low back pain ( )hear attacks ( )constipation
( )head pains ( )leg pain ( )high blood pressure ( )kidney trouble
( )neck pain ( )leg tingling ( )low blood pressure ( )menstrual cramps
( )shoulder tension ( )cold feet ( )anemia ( )menstrual irregularity
( )arm pain ( )sensitivity to light ( )rheumatic fever ( )diabetes
( )grating in neck ( )hay fever ( )nervous stomach ( )cancer
( )tingling in arms ( )sinus trouble ( )intestinal gas( )sleeping problems
( )shoulder blade pain ( )ringing in ears ( )ulcers ( )painful joints
( )throat inflammation ( )fainting ( )nervousness ( )swollen joints
( )mood changes ( )loss of balance ( )irritability ( )arthritis
( )twitching of face ( )cold hands ( )liver trouble ( )swollen ankles
( )loss of memory ( )chest pains ( )gall bladder trouble ( )T.B.
( )fatigue ( )shortness of breath ( )indigestion ( )HIV positive

Have you had any major falls, car accidents or injuries? ____ If yes please give month/year
____
____
____

Have you ever had any surgery? _____If yes, please give type and date (month/year)
____
____

Are you presently taking medication? ______ If yes please give type and what it is for:
____
____

We would like to welcome you to our office and explain our office fee schedule:

Initial consultation and examination	$50
Subsequent Visit	$40
Standard fee for routine x-ray examination	$90

Most extended health benefit programs include chiropractic in their benefits package. It is always up to the patient to determine their coverage levels and details.

Exempt Patients: The B.C. Medical Services Plan will subsidize chiropractic office visits if the income of an individual does not exceed a certain level. Patients that meet this requirement will have a total of ten visits for chiropractic, physiotherapy, massage therapy, and non-surgical podiatry.

X-ray examination is not covered by the B.C. Medical Services Plan. You are responsible for the X-ray fee at the time X-rays are taken.

Assignment of Medical Services Plan Benefits

I request that benefits payable to me under the Medical and Health Care Services Act for chiropractic services rendered by Dr. MacKenzie be made payable in my name and mailed to the following address:

Mackenzie Chiropractic Associates Inc.
101 - 1108 Austin Avenue
Coquitlam, BC V3K 3P5

Informed Consent to Chiropractic Treatment

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament sprains as a result of manual therapy techniques;

b) There are reported cases of stroke with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms.

Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same

symptoms. I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _______________ day of _______________, 20_____.

__________________________________	___________________________
Patient Signature (legal guardian)	Witness of Signature
Name: ___________________________	Name:______________________________