

Holly Meadows Chiropractic

420 Essa Rd. Unit 3C
Barrie, ON
L4N 9J7

Tel/FAX: (705) 728 9999

Rates Of Service

Initial visit, with or without treatment: \$75.00
Subsequent visit with treatment: \$38.00
Custom Orthotics: \$400

Patient Information

Name: _____ Age: _____
Address: _____ Home Phone#: (____) _____
City: _____ Province: _____ Postal Code: _____
Date of Birth: _____ E-Mail Address: _____
Marital Status (circle one): Married Single
of Children: _____
Occupation: _____
Employer: _____ Work Phone #: (____) _____
Emergency Contact: _____ Phone # _____

Health History

Reason for seeking chiropractic care: _____
Date of Onset/Accident: _____
Is this condition due to a/an (circle one): Auto Accident Work Injury Other

Name of Family Physician _____ Phone # _____
May we contact your physician with regards to your chiropractic care? YES NO

List any current medications: _____
List any past surgeries and dates: _____
List any past accidents and dates: _____
List any x-rays you have had in the past 2 years: _____

Chiropractic History

Have you ever been to a chiropractor before? _____
If yes, Doctor's Name: _____ City: _____
Date of last visit: _____ Reason for care: _____

FEMALES: Is there any possibility of you being pregnant? _____

How did you hear about our clinic? _____

Dr. Jennifer Malowney BSc, DC
Dr. Scott Best BA, DC
Chiropractor
Tel / Fax: 705 728 9999

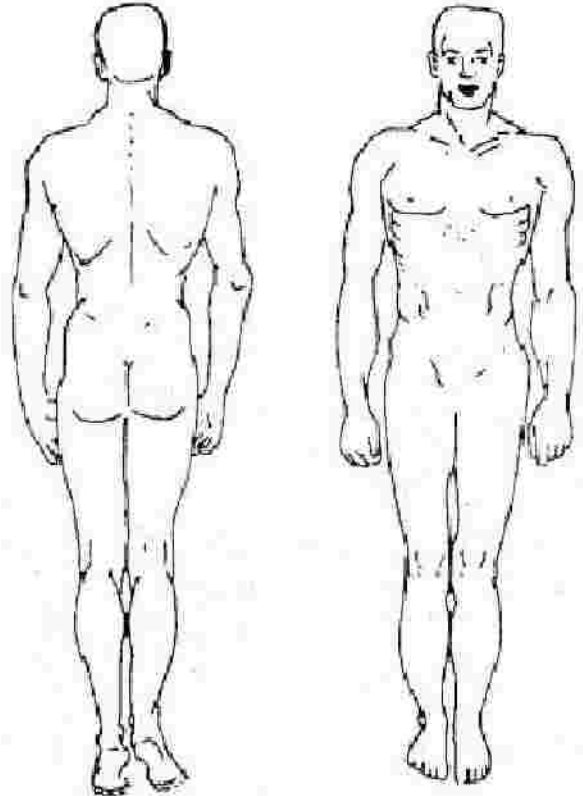
Patient Name

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If you have had the following, or if you suffer from the following, *Please Check*

- Headache
- Migraines
- Neck Pain
- Shoulder Pain
- Arm/Hand Pain
- Mid Back Pain
- Low Back Pain
- Hip Pain
- Leg/Foot Pain
- Arthritis
- Other joint pain
- Numbness
- Joint Swelling
- Dizziness
- Nausea
- Weakness
- Fatigue
- Nervousness
- Insomnia
- Heart Problems
- Vision Changes
- Nose Bleeds
- Ringing in Ears
- Earaches
- Hearing Loss
- Cough
- Chest pains
- HIV +, Hepatitis A, B, or C +
- Allergies
- Asthma
- Cancer
- Osteoporosis
- Diabetes
- Hypoglycemia
- Digestive problem
- Urinary Problems
- Frequent colds Skin conditions

Please use "X's" to mark areas of pain or discomfort



Please rate your pain on a scale of 0 (None) to 10 (Worst): _____

Please fill in any other health information you feel we might need for your care.

Your signature below please to consent to an initial examination.

Date: _____

Informed Consent

Please read: To be signed after you have had the opportunity to discuss with the chiropractor.

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 strains or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated 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 sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical 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.

Patient Signature _____ Date _____

Witness Signature _____ Date _____