hands-on healthcare CLINIC

209 Frederick Street, Suite 102, Kitchener, ON N2H 2M7 • P. 519.342.3123 • F. 519.342.3124
www.handsonhealthcare.ca

Welcome New Patient!

Personal Information

❒ Mr. ❒ Mrs. ❒ Miss ❒ Ms ❒ Dr.

Last name: _____First name and initials: _____

Date of birth: Day _____ Month _____ Year_____ Age: _____

Address: _____

_____

Postal Code: _____ Email: _____

Home Phone: _____Work Phone: _____ Ext:_____ Occupation: _____

Healthcare Information

Have you been to a chiropractor before? ❒Yes ❒ No If so, who? _____
Have you ever had x-rays of your spine? ❒Yes ❒ No If so, when? _____
Do you wear orthotics in your shoes? ? ❒Yes ❒ No If yes, how old are they? _____
Family Doctor's Name_____ Telephone ( ) _____
How did you hear about our clinic? ❒ Friend ❒ Family Member ❒ Massage Therapist
❒ Family Dr. ❒ Yellow pages ❒ Good Life Gym ❒ Chamber of Commerce ❒ Magnet
❒ Website ❒ Other _____

Health Information

What is your major health complaint? _____

_____

_____

How long has it been present? _____

Did it begin ❒ gradually ❒ suddenly?

What do you think has caused this problem? _____

_____

_____

What makes your symptoms worse? _____

What makes your symptoms decrease? _____

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Pain intensity – On a scale of 0-10 with 0 representing no pain and 10 being the worst pain you have ever had, how would you rate your pain? ___/ 10.

Do you have any other health complaints?

_____

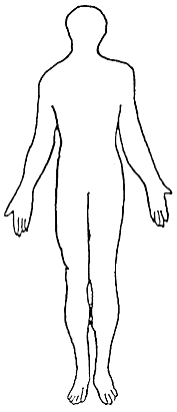
_____

_____

_____

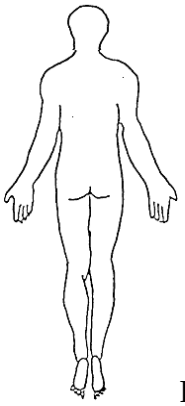
Please indicate the area of complaint(s) on the diagrams.

Front



Right Left

Back



Left Right

Please mark off the areas of your complaint on the diagrams. Use the following symbols to accurately describe your condition.

PPP – where you experience pain
NNN – where you experience numbness
TTT –where you experience tingling
CCC – where you experience cramping

Have you had any of the following illnesses? (Please ✓ all of these that apply)

❒ Asthma ❒ Stroke ❒ Hernia ❒ Anemia
❒ Diabetes ❒ Osteoarthritis ❒ Prostate Problems ❒ High Blood Pressure
❒ Rheumatoid Arthritis ❒ Cancer ❒ Heart Disease ❒ Osteoporosis
❒ HIV/ AIDS ❒ Other Illnesses _____

In your immediate family (parents, brothers or sisters) is there any history of:

❒ Stroke ❒ Cancer ❒ Diabetes ❒ Heart Disease Other diseases?

_____

_____

Have you ever been hospitalized? ❒Yes ❒ No If so please explain _____

_____

_____

Have you fractured any bones? ❒Yes ❒ No If so please explain _____

_____

_____

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Please list all surgeries (reason and date) _____

_____

_____

_____

_____

Have you ever been involved in a motor vehicle accident? ❒ Yes ❒ No If so , when?_____

_____

_____

_____

Do you have any of the following symptoms? (please ✓ all that apply)

❒ shortness of breath	❒ headaches	❒ sprains/ fractures	❒ chest pain	❒ earaches
❒ swollen glands	❒ chronic cough	❒ dizziness	❒ weakness	❒ allergies
❒ rapid weight changes	❒ difficulty sleeping	❒ tremors	❒ hip pain	❒ muscle spasms
❒ indigestion	❒ blurred vision	❒ nausea/vomiting	❒ blackouts	❒ frequent urination
❒ neck pain/stiffness	❒ difficult urination	❒ back pain/ stiffness	❒ depression	❒ chronic fatigue
❒ swollen joints	❒ swollen glands	❒ ankle pain	❒ knee pain	❒ elbow pain
❒ shoulder pain	❒ wrist/hand pain	❒ arm/hand pain or numbness		

OTHER SYMPTOMS _____

Have you ever been on birth control ?❒ Yes ❒ No Are you currently on birth control? ❒ Yes ❒ No

List any pills, vitamins or medications: _____

_____

How much do you exercise (type and frequency) _____

_____

In what position do you sleep? _❒Left Side ❒ Right Side❒ Both Sides ❒ Stomach ❒ Back

Do you smoke? ❒ Yes ❒ No If so, how much? _____

Do you drink alcohol? ❒ Yes ❒ No If so, how much? _____

# of Pregnancies _____ # Miscarriages _____ # Children _____ Ages _____

Name the 5 most stressful events in your life and when they occurred

_____

_____

_____

_____

_____

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Fee Schedule

Initial Visit - $100.00 Subsequent Visits - $ 46.00

Full Payment is expected when service is rendered. Payment can be made by Cash, Cheque or Debit. Returned cheques are subject to a $25.00 NSF charge.

PLEASE NOTE:
Missed appointments are subject to the FULL treatment fee.

The account is the responsibility of the patient. Workers Safety Insurance Board will be billed directly on your behalf for the charges incurred during treatment. It is the patient's responsibility to submit receipts to group health plans. Check with your health plan to determine details of your coverage.

Consent

I _____ have read the above, and agree and understand that I am responsible for all charges relating to my chiropractic treatment on the day that treatment is received. **I ALSO UNDERSTAND THAT I WILL BE CHARGED THE FULL TREATMENT FEE IF I MISS AN APPOINTMENT TO COMPENSATE FOR DR. HEAMAN'S TIME.**

Date: _____ Signature: _____

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Patient Privacy Consent Form
For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

AT HANDS-ON HEALTHCARE, THE PRIVACY INFORMATION OFFICER IS:

DR. DEBORAH HEAMAN

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that

- only necessary information is collected about you
- we only share your information with your consent
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our clinic. Please be assured that every staff person in the clinic is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses And Discloses Patients' Personal Information

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your health need's
- to advise you of treatment options
- to enable us to contact you
- to establish/maintain communication with you via telephone, newsletters, postcard reminders etc.
- to offer and provide treatment, care and services
- to communicate with other treating health-care providers, including specialists and referring doctors
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching on an anonymous basis
- to complete and submit claims for third party adjudication and payment in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- to comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients' chart and records in a timely fashion for regulatory and monitoring purposes

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- to permit potential purchases, practice brokers or advisors to evaluate the practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for the Health Professions Appeal and Review Board (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

By signing the consent section of this patient consent form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.
Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.
Our clinic will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.
You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process

Patient Consent

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I _____ allow Dr. Heaman to collect, use and disclose personal information about me, as set out above in the clinic's privacy policies.

Signature _____ Print Name_____

Date_____ Signature of Witness_____