Healthy Families
WELLNESS CENTRE

DR. KRISTY TOWELL, D.C. B.Sc

PATIENT ADMITTANCE FORM

FIRST NAME: _____ INITIAL: _____ SURNAME: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

DATE OF BIRTH (D/M/Y) _____/_____/_____ AGE: _____ GENDER: M / F

TELEPHONE: _____ CELL: _____ WORK: _____

EMAIL ADDRESS: _____

PRIMARY MEDICAL OR HEALTH PRACTITIONER: _____

WHO REFERRED YOU TO THIS CLINIC: _____?

HAVE YOU EVER SEEN A CHIROPRACTOR? YES ( ) NO ( ) DATE OF LAST VISIT: _____

CLINIC & DOCTOR'S NAME: _____

HAVE YOU HAD RECENT X-RAYS? YES ( ) NO ( ) WHERE? _____ WHEN? _____

PLEASE READ AND SIGN

Fees for chiropractic services, goods, and fees for completing insurance forms are the responsibility of the patient and are payable in full at the time of service. In the event that an insurance company, WSIB, or other agency will not provide treatment coverage, the patient is responsible for payment on the account. We will provide you with the appropriate statements to submit to your workplace or private **Extended Health Benefit Insurance Company** for consideration of reimbursement. The fee schedule is as follows:

SERVICE	TOTAL	SERVICE	TOTAL
Initial Examination	**$80.00**	**Acupuncture**	**$48.00**
Adjustment	**$48.00**	**Acupuncture & Adjustment**	**$63.00**
Senior (65+)	**$43.00**	**Ultrasound & Adjustment**	**$58.00**
Ultrasound	**$18.00**	**Ultrasound & Adjustment (65+)**	**$53.00**

Missed appointments will be charged at half the service fee for the service that was booked.
To avoid this charge, cancel or reschedule your scheduled appointment 24 hours prior.

The practice of chiropractic includes many standard examination and testing procedures. While chiropractic examination is remarkably safe, you need to be informed about the potential risks related to your examination to allow you to be fully informed in consenting to the examination. Muscle strains, ligament/joint sprains, and disc aggravations may occasionally occur.
I have read the above paragraph and I understand the information provided. I knowingly authorize Dr. Kristy Towell to proceed with a chiropractic examination.

Signature: _____ Date: _____

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DR. KRISTY TOWELL

PATIENT INFORMATION

DATE: _____

FIRST NAME: _____ LAST NAME: _____ INITIALS: _____

MAJOR COMPLAINT INFORMATION

WHAT IS YOUR MAHOR COMPLAINT(S)? _____

_____

_____

WHEN DID THIS SYMPTOM(S) BEGIN? _____

_____

_____

IF THIS IS AN INJURY, DESCRIBEWHAT HAPPENED? _____

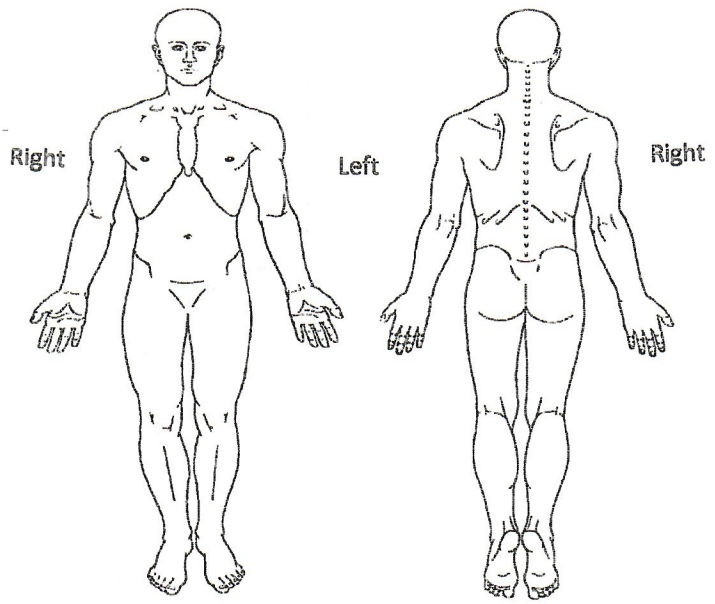
_____

_____

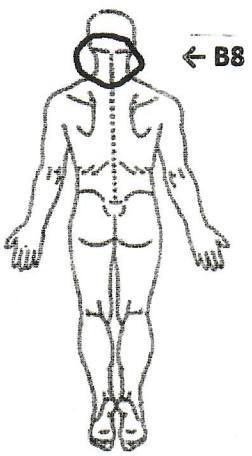
HAVE YOU EVER HAD? MOTOR VEHICLE ( ) SPORTS INJURY ( ) WORK INJURY ( ) SLIP & FALL ( )

IF YES, PLEASE EXPLAIN: _____

Using the symbols provided in the Pain Index Box, mark the areas on the illustration below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)



PAIN INDEX	
D	Dull Nagging Ache
B	Burning
S	Sharp/Stabbing
N	Numbness/Tingling



*For example: if you are experiencing moderately Severe burning pain in back of neck, you should note a **"B8"** on the neck illustration*

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HAVE YOU EXPERIENCED THESE SYMPTOMS BEFORE? YES ( ) NO ( ) WHEN? _____
WHAT AGGRAVATES THIS CONDITION? _____
WHAT DECRESES THE SYMPTOM/PAIN? _____
HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION? YES ( ) NO ( ) DOCTOR'S NAME: _____
DATE CONSULTED: _____ DIAGNOSED: _____
DOES THIS CONDITION INTERFERE WITH YOUR SLEEP? YES ( ) NO ( ) IF SO, HOW MANY TIMES DO YOU WAKE UP IN PAIN PER NIGHT? _____
IN WHAT POSITION DO YOU SLEEP? BACK ( ) SIDE ( ) STOMACH ( )
DO YOU SLEEP WITH A PILLOW? YES ( ) NO ( ) HOW MANY? _____
DOES HEAT AFFECT THE PAIN? YES ( ) No ( ) IF SO, HOW? _____
DOES COLD AFFECT THE PAIN? YES ( ) NO ( ) IF SO, HOW? _____
DO YOU WEAR A HEEL LIFT? YES ( ) NO ( ) IF SO, WHICH SIDE? RIGHT ( ) LEFT ( )
DOES IT CAUSE PAIN TO COUGH, GRUNT, OR SNEEZE? YES ( ) NO ( ) IF SO, WHERE? _____

CHECK THOSE ACTIVITIES BELOW DURINGWHICH YOU EXPERIENCE DIFFICULTY OR PAIN:

o Lying on back	o Dressing yourself	o Sitting
o Lying on side	o Sexual activity	o Bending forward
o Turning over in bed	o Pushing	o Bending backward
o Lying flat on stomach	o Pulling	o Sneezing
o Getting in/out of car	o Reaching	o Coughing
o Standing for long periods	o Kneeling	o Other:
o Walking	o Stooping	

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

LOWER BACK PAIN

DOES PAIN RADIATE INTO THE LEG? YES ( ) NO ( ) WHERE? _____
DOES PAIN RADIATE TO THE ABDOMEN? YES ( ) NO ( )
DO YOU EVER HAVE IMPAIRMENT OF BOWEL OR URINARY FUNCTION? YES ( ) NO ( ) Explain: _____
_____
DO YOU HAVE NUMBNESS OR TIGGLING INTO THE LEGS? YES ( ) NO ( ) EXPLAIN: _____
_____

NECK PAIN

IF YOU HAVE A NECK INJURY, DOES IT AFFECT: (CHECK ALL THAT APPLY)
HEARING ( ) VISION ( ) BALANCE ( ) CAUSING RINGING IN YOUR EARS ( )
DO YOU HEAR GRATING SOUNDS? YES ( ) NO ( )
DO YOU FEEL PRESSURE OR PAIN BEHIND YOUR EYES? YES ( ) NO ( )
DOES PAIN RADIATE INTO YOUR ARM? YES ( ) NO ( ) WHERE? _____
DO YOU HAVE DIFFICULTY LIFTING OR TURNING YOUR HEAD? YES ( ) NO ( )
IF SO, IN WHICH DIRECTION? RIGHT ( ) LEFT ( ) UP ( ) DOWN ( )

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HEADACHES

DO GET HEADACHES? YES ( ) NO ( ) FREQUENCY _____

DO YOU HAVE A FAMILY HISTORY OF HEADACHES? YES ( ) NO ( )

DO YOU EXPERIENCE THE FOLLOWING ALONG WITH YOUR HEADACHES?

PAIN OR CRACKING IN YOUR JAW YES ( ) NO ( )

ABNORMAL BLOOD PRESSURE YES ( ) NO ( ) IF SO, LOW ( ) HIGH ( )

NAUSEA, VOMITING OR VISUAL DISTURBANCES YES ( ) NO ( )

WHEN WAS YOUR LAST EYE EXAM BY A DOCTOR?

1-6 MONTHS ( ) 6-12 MONTHS ( ) 1-2 YEARS ( ) OVER 2 YEARS ( ) RESULTS: _____

IF FEMALE, ARE YOU PREGNANT? YES ( ) NO ( ) NOT SURE ( )

IF NO OR NOT SURE, DATE OF YOUR LAST MENTRAL PERIOD: _____

LIST OF ALL MEDICATIONSYOU ARE TAKING NOW, INCLUDING OVER THE COUNTER MEDICATION: _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATONS: YES ( ) NO ( ) NOT SURE ( ) PLEASE LIST: _____

TYPE OF HOSPITALIZATION/SURGERIES	DATE
_____	_____
_____	_____
_____	_____

ADDITIONAL COMPLAINTS

PLEASE CHECK ALL ADDITIONAL COMPLAINTS THAT YOU HAVE AT THIS TIME:

- o Loss of Concentration
- o Eyes Sensitive to Light
- o Heavy Feeling of Head
- o Memory Loss
- o Dizziness
- o Ringing in Ears
- o Loss of Balance
- o Loss of Smell
- o Loss of Taste
- o Pain Behind Ears
- o Fainting
- o Palpation
- o Neck Stiffness
- o Neck Motion Restricted
- o Upper Back Pain/Stiffness
- o Mid Back Pain/Stiffness
- o Right/Left Shoulder Pain
- o Right/Left Arm Pain
- o Pins & Needles Arms/Legs
- o Right/Left Leg Pain
- o Vision Problems
- o Sinus Trouble
- o Nervousness
- o Chest Pain
- o Shortness of Breath
- o Irritable
- o Anxiety
- o Depression
- o Insomnia
- o Fatigue
- o Excess Perspiration
- o Digestive Trouble
- o Nausea
- o Vomiting
- o Diarrhea
- o Constipation
- o Cold Hands
- o Cold Feet
- o Jaw Pain
- o Hypertension
- o Diabetes
- o Convulsions
- o Anemia
- o Heart Disease
- o Arthritis
- o HIV (Aids)
- o Allergies (Please List) _____

_____

_____

- o OTHER NOT LISTED:

_____

_____

_____

PLEASE SPECIFY LOCATION:

- o NUMBNESS _____
- o SWELLING _____
- o CUTS _____
- o BRUISING _____