INNOVA Medical and Rehab

Dr. Farhad Babakhani. BSc, DC, FCCRS, RAc
#111-1650 Elgin Mills Road East
Richmond Hill, ON L4S 0B2
Tel: (905) 884-2121
Fax: (905) 884-8845

PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ Postal Code: _____
Phone Number: (Home)_____ (Cell)_____
(Bus)_____
Email Address: _____
Would you like to join our Event List/Newsletter? ☐Yes ☐No
Date of Birth: _____/ _____/ _____ Age: _____ Gender: _____
(day) (month) (year)
Occupation: _____
Marital Status: _____
Spouse's Name: _____ No. of Children: _____
Were you referred to this clinic? ___Yes ____ No
If yes, whom can we thank for your referral?
_____
If No, how did you hear about this clinic?
_____

PATIENT HISTORY

Are you attending this clinic for a specific complain or for a spinal check-up?
_____ Specific Complaint
_____ Spinal Check-Up
If you have a specific complaint, please describe you main problem area:
_____
_____

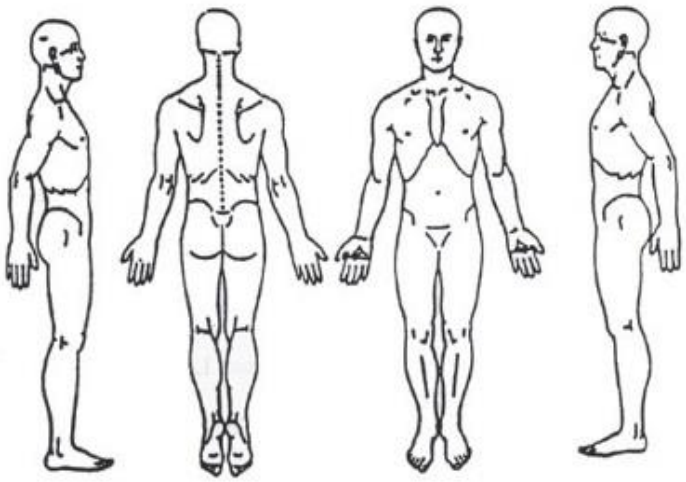
_____
Have you had this condition before? _____
If Yes, How long ago? _____
How long has this condition been bothering you? _____
Does this complain prevent you from doing any of your daily or recreational activities? _____
If Yes, please describe the activities that you are not able to perform:
_____

_____

PAIN DIAGRAM

Please describe your complain according to the diagram below. Please X's where you feel main. Use as many X's as necessary to describe where all your pain is felt.

Does any member of your family suffer from the same condition? _____
Have your children had a spinal check-up? And if Yes, where and when?
_____



Is your pain a result of a car accident? _____
If yes, when was the accident: _____
Is your pain a result of an accident that happened at work? _____
If yes, state the date of the accident: _____

PATIENT MEDICAL INFORMATION

Have you previously seen a: Chiropractor _____ Acupuncturist _____
Massage Therapist _____ Other _____
If yes, please state therapist's name: _____
Therapist Contact number: _____
Family Physician Name: _____
Family Physician Contact: _____
Are you taking any kind of medication, which includes birth control, aspirin or Tylenol?
____ Yes ____ No
If yes, Please name the medications: _____
Do you have allergies to any foods or medications? ____ Yes _____ No
If Yes, please describe: _____

MEDICAL CHECKLIST:

Do you or your immediate family suffer from or have suffered from any of the following?

Please indicate with a ✓

☐ Asthma	☐ Recurring Headaches	☐ Heart Trouble	☐ Kidney Stones
☐ Epilepsy	☐ Heart Trouble	☐ Hernia	☐ Arthritis/Rheumatism
☐ Allergies/Hives	☐ High/Low Blood Pressure	☐ Jaundice	☐ Stroke/Paralysis
☐ Fainting	☐ Cancer/tumor	☐ Kidney Stones	☐ Whooping cough
☐ Migraine Headaches	☐ Constipation/ Stomach Problems	☐ Diabetes	☐ Lumbago
☐ Dizziness	☐ Cyst	☐ Infection of Skin/Bone	

LIFESTYLE INFORMATION

Please check ✓ all applicable to your lifestyle.

☐ Smoke Tobacco

☐ Prescription Drugs

What Kind of Drugs and how often: _____

☐ Recreational Drugs

What kind of Drugs and how often: _____

☐ Drink alcohol

How frequently: _____

LIFESTYLE STRESS LEVEL

Please check ✓ all applicable to your lifestyle.

___ High ___ Moderate ___ Very Little

For Women Only

Do you Suffer from:

☐ Osteoporosis ☐ Painful Menstruation ☐ Premenstrual Syndrome ☐ Lump in breast

Are you Pregnant? ____ Yes _____ No ____ Not Sure

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective care). Still others want whatever is malfunctioning in their bodeis brought to the highest state of health possible with Chiropractic care (Preventative Care).

These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic care is always up to you.

Please check the type of care desires so that we may be guided by your wishes whenever possible:

☐ Preventative Care ☐ Corrective Care ☐ Relief Care ☐ Let doctor choose

CLINIC FEES

Initial Examination Fees

Adult (18 to 64)	$85.00	Innova Medical & Rehab Patients $55.00
Mature Adult (65 and older)	$60.00	
Junior (17 and under)	$60.00	
Progress Assessment (new complaints, recent trauma, assessment of progress)	$55.00	

*Note: A Progress Assessment is required when previous visit has been longer than 6 months.

Office Visits

Adult Fee (18 years and older)	$45.00
Child & Mature Adult Fee (12 and under, 65 and older)	$35.00
Combined Chiropractic & electro modalities	$45.00
Acupuncture	$45.00
Combined Chiropractic & Acupuncture Visit	$55.00
Laser Therapy: One Site	$35.00
Laser Therapy: Additional Site (on same visit)	$20.00
Combined Chiropractic & Laser visit (one site)	$55.00

Massage Therapy Visits (price includes HST)

30 min massage	$55.00
45 min massage	$75.00
60 min massage	$90.00

Physiotherapy Visits

Initial Examination	$85.00
Physiotherapy treatment (15-20 min)	$65.00
Combined Physiotherapy and Laser Therapy	$70.00

PAYMENT IS DUE ON THE SAME DAY THAT SEVICE IS RENDERED

Insurance receipts are provided upon completion of your appointment. If, for any reason, the financial responsibility of the recommended care becomes difficult, we would appreciate notifying us as soon as possible. Our office can then set up a treatment and payment plan that will meet your needs. We are concerned about your health, and will help you in any way we can.

CANCELLATION POLICY

For chiropractic care, massage therapy, physiotherapy and acupuncture: 24 hour notice is required for all cancellations.

Late cancellation/missed appointments will be billed the cancellation fee of $42.00. A missed Massage appointment will be billed at 50% of massage price. Showing up late to an appointment does not guarantee service or full treatment time.

I agree to this Schedule of Fees and to the Cancellation Policy

_____

Signature

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

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

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

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:_____**

(please print) **(please print)**