Dr. Philippa Carrie, B.Sc., D.C. Prenatal Webster Certified
Dr. Clark Konczak, M.Sc., D.C., FCCOS(C), FRCCSS(C)
General, Sports and Orthopedics Doctors of Chiropractic

Cedar Coast Chiropractic

Custom Orthotics and Therapeutic laser

Thank you for choosing Cedar Coast Chiropractic. We wish to provide you with the best chiropractic care available.
Please be neat and as complete as possible. The more information we have, the better we can understand your condition.
Although no specific result can be guaranteed, our goal is complete satisfaction so that you will wish to refer others.
We take pride in the fact that our happy & healthy existing patients refer more than 95% of our new patients.

Name _____ **Care Card #** _____

Birthdate (mm/dd/yyyy)_____ **Age**_____ **Email**_____

Address_____ **City**_____ **Postal Code** _____

Home (Landline) **#:**_____ **Work#**:_____ **Mobile#:**_____

☐ I would like my appointment reminders sent to me. (Very convenient. Get an email and or text the day before!)

My Medical Dr. / Walk-in Clinic is:_____ ☐ *If relevant to my treatment you may contact him/her.*

My Occupation:_____ **Employer**_____

Who referred you to this clinic? Google//Friend(Who?)/ Physio/RMT/Dr. (Who?) _____

Is this an ICBC or a WCB claim? YES/NO **If YES Please let the receptionist know, there are more forms for you to fill out.**

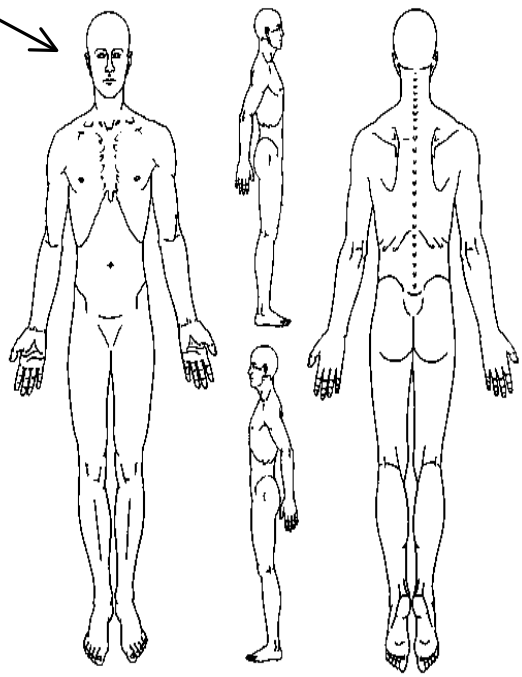
We may be able to bill your insurance directly. Please circle which carrier below.
Blue Cross, Green Shield, Great West Life, Sun Life, Co-Operators, Industrial, Johnson, other _____

Plan #_____ Id #_____ Primary's full name_____

Primary Cardholders Birthdate:mm/dd/yyyy _____ Primary's Plan Primary's ID#_____

What is (are) the reason(s) for your appointment?_____

Circle the problem areas related to your visit



Treatments have you tried. Physio,Chiro,RMT, Medications?

_____

Has it occurred before? YES / NO When?_____

How did it happen? _____

When did this condition start? _____

Is it related to job or auto accident? **No Job Auto**

What makes it feel worse?_____

What makes it feel better? _____

Is it getting better or worse or same? Better Worse Same

0 to 10? (0= No Pain and 10 = Worst)_____

Does the pain "shoot" or travel? YES/NO Where?_____

How often does the pain occur?_____

How long does the pain last? _____

CURRENT HEALTH AND INJURIES

Any Motor Vehicle Accidents? YES / NO
What happened ? Dates?_____

Any Work Injuries? YES / NO
What happened? Dates?_____

Any Sports Injuries? YES / NO
What happened? Dates? _____

Have you ever injured your head or lost consciousness? YES / NO When?_____

Is the reason for this visit also worsening your sleep? YES / NO How? _____

Have you seen a chiropractor? YES / NO Whom? _____ **When?**_____ **Why?**_____

PLEASE FILL OUT THE BACK OF THIS FORM

Have you had X-rays/CT/MRI/tests taken for this problem? YES / NO When?_____Where?_____

Past Hospitalizations or major illness (Serious reasons)_____

Surgeries and operations (Why?)_____

Medications/vitamins/tylenol/ibuprofen/birth control (What)?_____

Allergies?_____

DO YOU HAVE A FAMILY HISTORY OF? (Circle) Cancer Diabetes Heart Problems High Blood Pressure Stroke

DO YOU? (Circle and fill in)

Smoke or chew Tobacco:	**YES**	I Currently Smoke____ pack/day for____ years
	NO	BUT I USED TO. Quit how long ago? How much back then?
	NEVER	
Interrupted sleep:	**NO**	I sleep normally most of the time
	YES	It has been interrupted ____times/night for ____ months/years.
	YES	My current complaint is affecting my sleep

YOUR HEALTH HISTORY:

Have you experienced any of the following so that you required medical treatment OR you have noticed that the condition/symptom is worse associated with your current problem? (Please check all that apply)

- □ Fever/chills
- □ Recent weight loss or gain
- □ Anemia
- □ Fatigue
- □ Bleeding abnormalities
- □ Night Sweats
- □ Limitation of movement, where _____
- □ Headaches, type _____
- □ Heart Disease, heart attack
- □ High or low Blood Pressure
- □ High or low Cholesterol
- □ Persistent cough
- □ Difficulty breathing
- □ Frequent infections
- □ Chest pain
- □ Stroke
- □ Cancer
- □ Arthritis
- □ Osteoporosis
- □ Changes in vision, hearing, smell, or taste
- □ Dizziness
- □ Seizures, fainting, Epilepsy
- □ Insomnia
- □ Depression
- □ Anxiety
- □ Phlebitis
- □ Varicose Veins
- □ Diabetes
- □ Pregnancy (past/currently)
- □ Menstrual problems
- □ Constipation
- □ Gastrointestinal Problems
- □ Blood in urine or stool
- □ Kidney or Bladder problems
- □ Psoriasis
- □ Contagious skin condition
- □ Allergies, type _____
- □ HIV/AIDS/Hepatitis
- □ Swollen joints
- □ Spinal Curvature/Scoliosis
- □ Numbness or weakness

Is there anything else not covered here that the doctor should be aware of? NO / YES (Write Below)

Assignment of Medical Services/Insurance Plan Benefits to Dr. Carrie / Dr. Konczak

I authorize the Medical Services Plan/my insurance to pay Cedar Coast Chiropractic directly for all reimbursements for benefits payable to me under the Medical and Heath Care Services Regulation for care provided to me by my Practitioner.

I make this assignment in full knowledge of the amount that I will be personally responsible for the difference between the office fee and the amount that is reimbursable by the Medical Services Plan ($23) or my insurance co-pay. The amount reimbursed by MSP or my insurance will be directed to Cedar Coast Chiropractic and be applied against any outstanding monies I owe for services provided.

This form allows your practitioner to receive your reimbursement directly for services that are your benefits. Your practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed by MSP or your insurance. By agreements, your practitioner may not charge you the portion reimbursable by MSP. I understand that any benefits over and above the treatments allotted per year will be my responsibility to pay in full at the private fee rates.

In consideration of other patients and my practitioner, I understand that a minimum of 24 hours notice is required to change or cancel my appointment.

I am aware that I will be charged the full-fee and it is my responsibility to pay for the treatment fee in the case of late cancellations or missed appointments.

Signature:_____ Date:_____