Baden Integrative Health

Please Print Clearly ***Please Complete All Information***

Who can we thank for your referral? (internet, friend, family) _____

Name: _____ Birthdate: (mm/dd/yyyy):_____ Gender: M/ F

Address: _____ City:_____ Postal Code:_____

Home Phone:_____ Cell: _____ Work: _____

Email Address:_____
Do we have your permission to send you emails (for appointment reminders, newsletters etc? (Yes / No)

Occupation:_____ Company: _____

Do you have extended healthcare? Yes/ No If yes, who with?_____

Have you had previous chiropractic care? Yes / No When was your last visit?_____

Who is your Medical Doctor? _____

Who is your Massage Therapist? _____Other Healthcare Practitioner?_____

Welcome to Baden Inegrative Health! We want you to understand and consent to the services we provide to you, the costs involved, and what we do with personal inforamtion we obtain about you. If you have questions about any of this, please ask.

Our expectations of patients for services rendered by Baden Inegrative Health:

- We expect all patients to pay for all services when they are provided. If you do not pay for a service at the time it is received, an interest rate of 3% per month will be applied to all outstanding balances and, on default, to pay all costs of recovering debt, including and/ or agent costs.
- We expect all patients to provide **24 hours notice when cancelling an appointment**. Your appointment time is reserved exclusively for you and our professionals cannot use this time to see other patients if you do not provide 24 hours notice or cancellation; you agree to pay our standard fee for the missed appointment, as if you had attended.
- The fee schedule is: New Patient Examinations if $80.00. Subsequent Treatments are $40.00, Acupuncture is $50.00, Extended Sessions $55.00, Re- assessments (greater than 3 months) are $65.00.

Patient Signature: _____ Date:_____

Past Medical History

Any major surgeries or hospitalizations:_____

Lifestyle Factors

Do you smoke? Yes/ No How many packs per day?_____ for _____ years

What do you do for fun? _____ To stay active? _____

Please check any symptoms that you have had in the past or are presently experiencing.
Mark the boxes: C= Current P= Past

MUSCULOSKELETAL	***GENERAL***	***CARDIOVASCULAR***
Low Back Pain	Fatigue	Chest Pain
Mid Back Pain	Allergies	Short of Breath
Neck Pain	Loss of Sleep	High Blood Pressure
Arm Pain	Fever	Irregular Heartbeat
Join Pain/ Stiffness	Headaches	Lung Problems
Problems Walking	Night Pain	Varicose Veins
General Stiffness		Ankle Swelling
	GENTIO- URINARY	Calf Pain
NERVOUS SYSTEM	Bladder Trouble	Stoke/ Heart Pain
Nervousness	Painful Urination	
Numbness	Discolored Urine	***GASTROINTESTINAL***
Paralysis		Decreased Appetite
Dizziness	**EENT**	Excessive Thirst
Forgetfulness	Vision Problems	Frequent Nausea
Confusion/ Depression	Sinus Problems	Vomiting
Fainting	Ear Aches	Diarrhea
Convulsions/ Seizures	Difficulty Hearing	Constipation
Tingling	Frequent Colds	Hemorrhoids
Loss of Sensation		Liver Problems
Stress =	***MALE/ FEMALE***	Abdominal Cramps
Rate your stress level on a scale of 1- 10 (10= highest)	Irregular Menstruation	Weight Loss
	Menstrual Cramps	Gas/ Bloating
	Vagina Pain/ Infections	Heartburn
	Breast Pain/ Lumps	Black/ Bloody Stool
	Prostate Problems	Colitis
	Other	Crohn's Disease

Any other medical conditions not listed:

_____

_____

Patient Signature: _____ Date:_____

People seek the care of a Chiropractor for many reasons; please check the one that applies to you so we can serve you better.

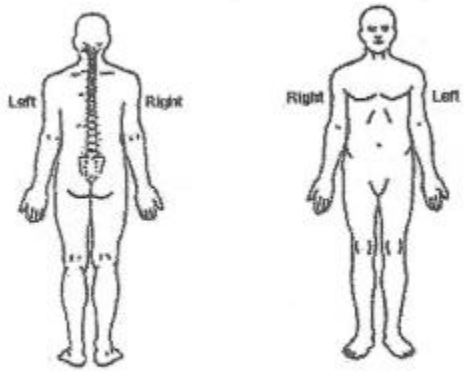
_____ I have a specific problem and only require help with this problem
_____ After my problem, has been relived I want to ensure the problem does not return
_____ Spinal check-up and to improve my general health

Reason for appointment/ current complaint: _____

Is this condition: Auto Related / WSIB Claim / Sport Injury / Gradual Onset / Other: _____

Please circle the following diagram based on location of pain or discomfort.

Dull Ache	(A)
Sharp	(H)
Tingling	(T)
Numbness	(N)
Burning	(B)
Stiffness	(F)
Tight	(G)
Other	(X)



Please place an x on the grade indicating the severity of your pain.

(Least) 1 2 3 4 5 6 7 8 9 10 (Worst)

Is your complaint: Constant / Intermitted / Re- Occurring

Have you seen someone else for this condition?_____

Type of Treatment: Results: _____

Current Medications: Pain Killers / Muscle Relaxants / Blood Pressure / Insulin / Anticoagulants

Please List: _____

Patient Signature: _____ Date: _____