



Chiropractic and Massage in the Village Dr. Katherine Clayton, B.A. D.C.

File No: \_\_\_\_\_

### General Information

How do you wish to be addressed in our office?

First Name       Mr./Mrs.     Miss       Doctor       Other \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

D.O.B. (d/m/y) \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender: Male Female

Address: \_\_\_\_\_ Town/City: \_\_\_\_\_ Postal: \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Spouse's name (if applicable): \_\_\_\_\_

Children: Y N      Number: \_\_\_\_\_ Ages: \_\_\_\_\_

(Females) Are you pregnant? Y N    If yes, how many weeks? \_\_\_\_\_

Do you have a midwife/doula? \_\_\_\_\_

Family Dr.: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Previous Chiropractic Care? Y N If yes, Doctor's name: \_\_\_\_\_

How did you decide to choose our office?

- Referral (*by a friend/family/other practitioner*): please specify \_\_\_\_\_
- Walking/driving by       website
- Midwife       Presentation
- Sign       Other \_\_\_\_\_

Reason for consulting the office:

- I have a specific problem and require help only with this problem.
- After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.
- After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
- I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.



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I understand that I am financially responsible for all services rendered and costs incurred at Chiropractic and Massage in the Village.

I agree to provide at least 24 hours notice when cancelling or rescheduling an appointment. I am aware that failure to provide 24 hours notice may result in being charged for the missed appointment.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_



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**Privacy Policy**  
**Chiropractic and Massage in the Village**

Privacy of personal information is important to Chiropractic and Massage in the Village. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be as open and transparent as to how we handle personal information.

**Personal Information**

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; the health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and destruction of your personal information complies with existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario, and the applicable law.

**Staff Members**

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, the clinicians and interns that provide you with chiropractic services, the clinic administration and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

**Disclosure of Personal Information**

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act

2242A Bloor Street West Toronto, On M6S 1N6 Tel: 416-766-1200



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- To process payments and collect unpaid accounts
- For research purposes

**Other**

Occasionally Chiropractic and Massage in the Village may use your name on our internal referral board within the confines of the clinic in order to thank you for your referrals to us. Please check the following box if you do not wish to be thanked on our internal referral board.

Staff at Chiropractic and Massage in the Village may contact you and leave a message on either your answering service or e-mail to remind you of an appointment. Please check the following box if you do not wish to be left any voicemail  or e-mail  messages.

By reading this policy, 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.



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File No: \_\_\_\_\_

**Health History**

File No: \_\_\_\_\_

The following health history is designed to uncover all areas of ill health. As the human body is designed to be healthy, any deviation from optimal health will reduce your body's potential. A detailed history can give your chiropractor valuable insight into the overall condition of your body. Your health history includes your journey from childhood to present. Please take the time to fully complete this form to the best of your ability:

**A. Growth and Development**

Y N Did your mother have a difficult delivery with you?

Explain: \_\_\_\_\_

Y N Was there any intervention employed with your birth? (forceps, vacuum extraction, epidural, c-section)

Explain: \_\_\_\_\_

Y N Did you ever experience a fall (out of bed, off a change table, table etc.) as an infant/toddler?

Y N Childhood illnesses? Which? \_\_\_\_\_

Y N Childhood Accidents? (include sports injuries, slips and falls etc.) Explain: \_\_\_\_\_

Y N Did you ever play contact sports? Please list: \_\_\_\_\_

Y N Have you ever been told you have a scoliosis?

Y N Any other childhood traumas? Explain: \_\_\_\_\_

Y N Were you vaccinated as a child?

Y N Did you have any childhood allergies? If yes, which ones: \_\_\_\_\_



**B. Current Health Status**

Y N Have you had any past surgeries? If so, what:  
\_\_\_\_\_

Y N Do you smoke? If yes, how many packs per day? \_\_\_\_\_

Y N Have you smoked in the past? Date quit: \_\_\_\_\_

Y N Do you drink any alcohol? If so, how much/week? \_\_\_\_\_

Y N Do you feel that you have an adequate balance of fresh vegetables and fruit in your diet?

Y N Have you ever been in a motor vehicle collision (including minor ones)?  
Explain: \_\_\_\_\_

Y N Have you had any other accidents, trauma or fractures? Explain:  
\_\_\_\_\_

Y N Have you had any previous X-rays or special imaging? (ie. CT scan, MRI, bone scan) If yes, where were these special tests done?  
\_\_\_\_\_

Y N Previously diagnosed conditions? List:  
\_\_\_\_\_  
\_\_\_\_\_

Y N Drugs / Prescription / Over the counter / Recreational / Birth Control? If yes, list drug and condition:  
\_\_\_\_\_

Y N Dental problems? Explain:  
\_\_\_\_\_

Y N Ear, Nose, Eyes, Throat problems? Explain:  
\_\_\_\_\_

Y N Regular exercise? Aerobic Non aerobic \_\_\_\_\_ x/week

|                   |                               |                                |                               |
|-------------------|-------------------------------|--------------------------------|-------------------------------|
| Stress:           | Occupational Y N              | Physical Y N                   | Mental Y N                    |
| Sleeping Posture: | Back <input type="checkbox"/> | Front <input type="checkbox"/> | Side <input type="checkbox"/> |



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File No: \_\_\_\_\_

Hours of sleep per night on average: \_\_\_\_\_/night

**C. Health Symptoms**

Ill health symptoms often appear after years of underlying dysfunction. Please briefly describe any current symptoms you are experiencing: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long ago did the problem(s) start? \_\_\_\_\_

The pain you experience is:     **CONSTANT**                    **INTERMITTENT**

What aggravates your pain / problem? \_\_\_\_\_

What relieves your pain or problem? \_\_\_\_\_

Does your pain radiate, or travel to other parts of your body? **Y N** Location: \_\_\_\_\_

\_\_\_\_\_

Please rate the intensity of your pain: 10 9 8 7 6 5 4 3 2 1 0  
  **HIGH           MEDIUM       LOW**

Does your condition get worse at certain times of the day or night? \_\_\_\_\_

\_\_\_\_\_

Is your condition getting: **WORSE**                    **BETTER**

Please describe the character of your pain (circle all that apply)

Dull/Achy Stiff/Tight Sharp/Stabbing/Shooting Numbness/Tingling Burning  
Catching Other: \_\_\_\_\_

Have you consulted with other health professionals regarding this problem? **Y N**  
If yes, which ones? \_\_\_\_\_

Have you taken any medications for this problem? **Y N**  
If yes, what medication and for how long? \_\_\_\_\_



Family History of: Heart Disease Stroke Cancer Diabetes  
who in your family has these conditions? \_\_\_\_\_

**D. Other symptoms**

Please place a check on the line if you currently experience or have experienced any of these in the past:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Fever   |
| <input type="checkbox"/> Neck Pain                   | <input type="checkbox"/> Depression           | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Back Pain                   | <input type="checkbox"/> Memory loss          | <input type="checkbox"/> Hepatitis B   |
| <input type="checkbox"/> Sleeping problems           | <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> HIV   |
| <input type="checkbox"/> Stress                      | <input type="checkbox"/> Ear infection        | <input type="checkbox"/> Trouble with bowel<br>or bladder<br>control                                 |
| <input type="checkbox"/> Irritability                | <input type="checkbox"/> Heart Trouble        | <input type="checkbox"/> Reproductive<br>problems<br>(endometriosis,<br>fibroids,<br>impotence etc.) |
| <input type="checkbox"/> Chest pains                 | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Mental Health<br>Problems   |
| <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Loss of balance      |  |
| <input type="checkbox"/> Stiff neck                  | <input type="checkbox"/> Fainting             |  |
| <input type="checkbox"/> Pins and Needles in<br>legs | <input type="checkbox"/> Loss of smell        |  |
| <input type="checkbox"/> Pins and Needles in<br>arms | <input type="checkbox"/> Stroke               |  |
| <input type="checkbox"/> Numbness in fingers         | <input type="checkbox"/> Loss of smell        |  |
| <input type="checkbox"/> Painful menstruation        | <input type="checkbox"/> Diarrhea             |  |
| <input type="checkbox"/> Numbness in toes            | <input type="checkbox"/> Stomach upset        |  |
| <input type="checkbox"/> Shortness of breath         | <input type="checkbox"/> Abdominal Pain       |  |
|  | <input type="checkbox"/> Constipation         |  |
|  | <input type="checkbox"/> Cold Sweats          |  |

**E. Expectations:**

Please list your top 3 expectations that you have regarding your care at Chiropractic and Massage in the Village:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

*Thank you for taking the time to fill out our general information form. Please return this form to the front desk. Further instructions will come shortly.*

*We look forward to working with you to achieve all of your health goals.*

*The Chiropractic and Massage in the Village Team*