Chiropractic Generation
#230 - 100 Bell Boulevard
BELLEVILLE, ON K8P 4Y7
(613) 966-4725

Introduction

Welcome to Chiropractic Generation!

WHAT TO EXPECT

YOUR FIRST VISIT

During your first visit we will go through a discovery process with you, to determine the source of your health concerns.

THIS WILL INCLUDE:

A DETAILED HEALTH HISTORY with one of our exam specialists.

A THOROUGH SPINAL EXAMINATION to determine any abnormal alignment and motion patterns, and also to discover how this is detrimentally affecting your central and peripheral nerve systems and organ function.

Sending you for ANY FURTHER IMAGING STUDIES that may be necessary such as x-rays.

YOUR NEXT APPOINTMENT

After the examination, if your doctor determines that you area a good candidate for reconstructive or structural Chiropractic care, he will then arrange for your next visit, which is the DOCTOR'S REPORT. The purpose of the DOCTOR'S REPORT is to review the findings from your consultation and examination.

At the DOCTOR'S REPORT, the doctor will give a detailed overview of how structural Chiropractic works and the scientific evidence supporting the specialized work that we do here. This will be done in a SMALL GROUP SETTING with other new patients.

We know that there is tremendous power in you fully understanding your problem and how we will work with you to correct it. This is why the DOCTOR'S REPORT is detailed and very informative.

We ask that your spouse come to the DOCTOR'S REPORT with you. Health information can be complicated and it can be difficult to explain your results to your spouse if they are not present at the REPORT. Having support

and understanding at home is important to your complete recovery.

After the presentation your doctor will privately review the results of your EXAMINATION AND X-RAYS. HE WILL OUTLINE A COURSE OF CARE, discussing how long it will take to correct your spine, how often you will come in for adjustments, and the financial investment for your care and correction. At that point you will be able to decide how you would like to proceed.

YOU ARE IN GOOD HANDS. Your health is our #1 priority.

Thank you for giving us the privilege to determine if we can help you OPTIMIZE YOUR HEALTH.

Sincerely,

Dr. Stephen Lippitt and the Chiropractic Generation Team

Please complete the following pages to save time and help us to serve you better. Thank you.

Contact

First Name_____ Last Name_____

Address _____

City_____ Prov_____ Postal_____

Gender Male Female Date of Birth_____

Height _____ Weight _____

Parent/Guardian

First Name_____ Last Name_____

Home Phone_____ Cell Phone_____ Email_____

How did you hear about us? None Patient Physician Attorney Advertisement

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History

Complications during pregnancy? Yes No

Ultrasounds during pregnancy? Yes No

Medications during pregnancy? Yes No

Cigarette/alcohol use during pregnancy? Yes No

Location of Birth: Hospital Home Other

Birth intervention performed: Forceps Vacuum Ex. C-Section

Delivery Medication? _____

Delivery Complications? Yes No

Birth Weight _____ Birth Length_____ APGAR Scores_____

Breast Fed? Yes No

Formula Yes No

Name of Pediatrician _____ Date of Last Visit _____

Reason for Visit_____ Treatment_____

At what age, in months, was the following introduced?

Solids:_____ Cows's Milk:_____

At what age, in months, was your child able to?

Respond to Sound: _____ Respond to Visual Stimuli: _____ Hold Head Up:_____

Stand Alone: _____ Crawl:_____ Walk Alone:_____

Sit:_____

Personal Illness History ADHD Falling Allergies Asthma Auto Accident Bed Wetting Chronic Colds Colic Constipation Diarrhea Digestive issues Ear Infections Headaches Recurring Fevers Scoliosis Seizures Temper Tantrums Traumat. Birth Vaccine Reaction Other

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Vaccination history_____

Family History_____

Please list any vitamins, herbs, or minerals the child takes: _____

Childhood Diseases

Chicken Pox Yes No

Rubeola Yes No

Whooping Cough Yes No

Rubella Yes No

Mumps Yes No

Other Yes No

Childhood Injuries

Fractures Yes No

Auto Accident Yes No

Spinal Injury Yes No

Hospitalization Yes No

Surgery Yes No

Number of doses of antibiotics your child has taken:

Last 6 months: _____ Since birth: _____

Number of doses of other prescription medications your child has taken:

Last 6 months: _____ Since birth: _____

Child's daily habits (skip any questions that do not apply):

Hours of sleep per night (1-24)_____

Child's exercise Heavy Daily Moderate None

Average amount of time spent watching TV, playing video games, or using a computer per day: None 1-3 4-6 7-12 Over 12

How often does this child consume:

Caffeine Drinks: Never Occasionally Daily

Sugar/sweets: Never Occasionally Daily

Dairy Products: Never Occasionally Daily

Wheat Products: Never Occasionally Daily

Fruits/Vegetables: Never Occasionally Daily

Water as a beverage: Never Occasionally Daily

Condition

Present problem:_____ First occurrence of condition:_____

Did something specific cause this condition? (please describe)_____

Since the problem started, is it: Improving Same Worse

Does anything make it better? Yes No

_____

Does anything make it worse? Yes No

_____

Other health professionals seen for this problem (please list name and dates if applicable)

Chiropractor _____

Medical Doctor_____

Other_____

Finalize

Please Read the following carefully before signing.

PLEASE READ CAREFULLY

In order for the Doctor of Chiropractic indicated below to make a determination on the suitability of my case for

chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiographic examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by the Chiropractor indicated below, or any party authorized to do so by that Chiropractor.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that Chiropractic care is considered very safe with an extremely low-risk rate. I further understand that there are, however, some risks associated with chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

In particular, I understand that in rare cases there have been reported incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapists, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements, including turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to a stroke. The risk of stroke after cervical adjustment is estimated at 1 in 1,000,000, substantially lower than that associated with any medical or other treatment medications or procedures for the same symptoms. To put this in perspective, studies that have assessed the risk from interventions a non-Chiropractor commonly uses for the same complaints have found the following:

Risk of paralysis or stroke from surgeries for neck pain: 15,600 per million

Risk of death from surgeries for neck pain: 6,900 per million

Risk of serious gastrointestinal event from non-steroidal

anti-inflammatory drugs: 1,000 per million

I understand that while rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments. I also understand that there have been rare reported cases of disc injuries following cervical and lumbar adjustments although no scientific study has ever demonstrated such injuries are caused or may be caused by chiropractic treatment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid

directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I have read and understood the above, and I have had sufficient opportunity to discuss its content with the Doctor of Chiropractic indicated below. I do hereby request and consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic indicated below, for my present condition and for any future conditions for which I may seek care. I also agree to payment for all services rendered.

Relationship to patient _____