Binbrook Chiropractic & Physiotherapy 3065 Highway 56 Binbrook, ON L0R1C0

# HEALTH HISTORY FORM

***For Your Information:***
An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Preferred Name (if any): _____

Address: _____ Today's Date: _____

City: _____ Postal Code: _____

Telephone Number (Home): _____ (Work): _____ (Cell):_____

E-mail Address: _____

Date of Birth: _____/_____/_____ Gender: M / F Occupation: _____
Month Day Year

Primary Care Physician: _____ Address: _____

Previous Chiro / Physio / Massage Care:_____ Last seen:_____

For what condition:_____ Results:_____

MVA or WSIB Claim number: _____

Emergency Contact Name and Phone Number:_____

**Health History**: please indicate conditions you are experiencing or have experienced.

**Respiratory**
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ other _____

**Cardiovascular**
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ CCHF
- ☐ heart attack
- ☐ phlebitis
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ other _____

**Family History**
- ☐ arthritis
- ☐ cancer
- ☐ diabetes
- ☐ heart disease/stroke

**Other Conditions**
- ☐ diabetes: onset _____
- ☐ allergies _____
- ☐ cancer
- ☐ arthritis
- ☐ migraines &/or headaches
- ☐ loss of sensation
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss
- ☐ skin conditions
- ☐ hepatitis
- ☐ TB
- ☐ HIV
- ☐ other _____

_____

**Cigarette/Tobacco Consumption**
- ☐ yes – amount _____/day
- ☐ no

**Women**
- ☐ pregnant: - due: _____

**Soft Tissue/Joint Discomfort**
- ☐ neck
- ☐ low back
- ☐ mid back
- ☐ upper back
- ☐ shoulders
- ☐ arms
- ☐ hands
- ☐ hips
- ☐ legs
- ☐ knees
- ☐ feet
- ☐ other _____

**Rate your General Health**
- ☐ above average
- ☐ average
- ☐ below average

Continued on back of page…

**Are you currently taking any medications?** _____

What is your **Current complaint?** _____

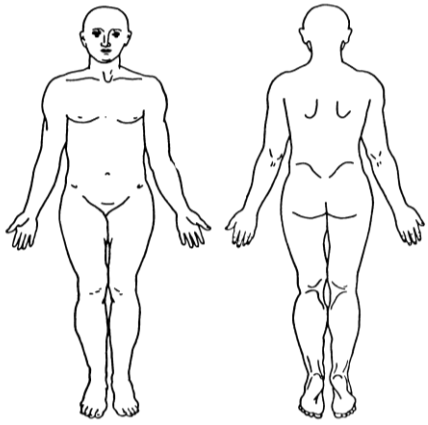
Has this condition occurred before? Yes/No

When did this condition begin? _____

Is the condition: ☐ Job-related ☐ Auto-related
☐ Fall ☐ Home Injury ☐ Other: _____

Date of Accident: _____

What happened? _____



Please mark on the diagram the area of your discomfort and any radiation of pain.

**Circle the grade to indicate the severity of your pain:**

LEAST 0 1 2 3 4 5 6 7 8 9 10 WORST

Have you gone for any x-rays, ultrasounds, MRI's etc. for ***this injury/problem?*** YES / NO

If YES, where? _____and approximately when? _____

Surgeries/Major Injuries (Nature/Date): _____

Presence of internal pins, wires, artificial joints, special equipment, etc._____

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb
☐ Burning ☐ Intermittent ☐ Constant

Does the pain radiate anywhere? ☐ No ☐ Arm (L or R) ☐ Leg (L or R) ☐ Other: _____

When does it hurt? ☐ Morning ☐ Evening ☐ wakes me up at night ☐ Other: _____

Please describe how it feels when this problem is at its worse: _____

**How did you hear about Binbrook Chiropractic & Physiotherapy?** ☐ Referral from Doctor ☐ Friend/Patient ☐ Sign ☐ Flyer/Advertisement ☐ Other: _____

# PRIVACY POLICY
# PATIENT DISCLOSURE FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality Physiotherapy care. We understand the importance of protecting your personal information, and are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Harnek Gill acts as the Privacy Information Officer.
All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what your office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards or our regulatory body, the College of Physiotherapists of Ontario, and the law

Do not hesitate to discuss our policies with any member of our office staff. Please be assured that every staff person in our office is committed to ensure that you receive the best quality care.

# PRIVACY POLICY

## How Our Office Collects, Uses and Discloses Patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care;
- To identify and to ensure continuous high-quality service;
- To assess your health needs;
- To provide health care;
- To advise your treatment options;
- To enable us to contact you;
- To establish and maintain communication with you;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up treatment and care;
- For teaching and demonstrating purposes on an anonymous basis;

- To complete and submit claims for third party adjudication and payment;
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the College of Physiotherapists of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professionals Act;

- To prepare materials for the Health Profession Appeal and Review Board (HPARB);
- To invoice for goods and services;
- To process credit card payments;
- To comply generally with the law;

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information; we will seek your approval in advance.

Your information may be accessed by the regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purpose of the College of Physiotherapists fulfilling its mandate under the RHPA, and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information.

We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and that process.

## PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.
I agree that Binbrook Chiropractic & Physiotherapy can collect, use and disclose personal information about me as set out above in the information for Binbrook Family Chiropractic.

_____ _____

Signature Print Name

_____

Date

Binbrook Chiropractic & Physiotherapy 3065 Highway 56 Binbrook, ON L0R1C0

**CCPA**

# CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

**Benefits** - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

**Risks** - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

●**Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
●**Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar. ●
●**Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
●**Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
●**Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
●**Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

**Alternatives** - Alternatives to chiropractic treatment may include consulting other health professionals, over-the counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

**Questions or concerns** - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

**Do not sign this form until you meet with the chiropractor.**

_____
Patient Name (print)

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian Signature | Date | Chiropractor Signature |

**Updated: September 2025**

# Cancellation Policy
# Binbrook Chiropractic & Physiotherapy

Your appointments and well-being are very important to us. We understand that sometimes, unexpected delays can occur, making schedule adjustments necessary. If you need to cancel your appointment, we respectfully require at a minimum 24 hour notice.

Our Policy:

● Any cancellation or reschedule made less than 24 hours prior will result in a cancellation fee. **The amount of the fee will be equal to 100% of the reserved services.**

● If you are more than15 minutes late for your service, we may not be able to accommodate you. In this case, the same cancellation fee will apply.

● We require a credit card to hold your appointment. Cancellation fees will be charged to your card on file.

● Insurance cannot be billed for missed appointments.

● We will do our best to contact individuals to provide courtesy reminders, but they are not guaranteed, or to be relied upon.

● In the event of a true, unavoidable emergency, all or part of your cancellation fee may be applied to future services.

**I hereby authorize Binbrook Chiropractic & Physiotherapy to charge my credit card in accordance with this cancellation policy**.

Name on Card: _____

Credit Card Number: _____

Expiry Date: _____ CVV:_____

Client Signature: _____

Date: _____