LaHave River Chiropractic and Health Centre

Health Questionnaire

Date (MM/DD/YY) ____ / ____ / ____

Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑

Last Name: ______________________________ First Name __________________________ Female ❑ Male ❑

Birthdate (MM/DD/YY) ____ / ____ / ____ Health Card No. ____

Address: ____

City: ______________________________ Province / State ______________________ Postal Code __________

Marital Status ____________________________Children __________

Home Telephone (____) _______________ Bus Telephone (____) _______________

Employer ______________________________ Occupation______________________________________

Email ____

May we add you to our email list? Yes ❑ No ❑ *Your email address will not be shared.*

What do you wish to get out of coming to our Health Centre?

❑ Increased well being and health, longer life

❑ Better physical health

❑ Relief from pain

What is your greatest concern regarding your health at this time? ______________________________________

____

____

Please tell us about your family history.

Is your father still living? ❑ Yes How is his health? What illness does he have, if any? ______________________

____

❑ No How old was he when he died and what was the cause?______________________

____

Is your mother still living? ❑ Yes How is her health? What illness does she have, if any? ____________________

____

❑ No How old was she when she died and what was the cause?___________________

____

Do any of your grandparents, parents, siblings have or have been diagnosed with:

❑ High Blood Pressure ❑ Diabetes ❑ Thyroid problems

❑ High Cholesterol ❑ Cancer ❑ Kidney Disease

❑ Heart Disease ❑ Stroke ❑ Arthritis

❑ Other____

LaHave River Chiropractic and Health Centre

Health Questionnaire - Page 2

Lifestyle and Health History

Do you smoke? ❑ Yes How many packs per day? ________ ❑ No When did you quit? ______________________

Do you consume alcohol? ❑ Yes ________ Drinks per week. ❑ No

List any falls or accidents you have had ____

____

List all surgeries you have had with the dates ____

____

____

List all medications you are currently taking ____

____

____

List all vitamins and supplements you are currently taking ____

____

____

Are you currently experiencing pain anywhere? ❑ No ❑ Yes Where? ____________________________________

For how long? _________________________ Is it increasing or decreasing in intensity? ________________________

On a scale of 1 to 10 (ten is really bad pain) rate the pain ____

What makes it worse? _____________________________________ Better? _______________________________

Have you had any X-rays or Scans? ____

Is this injury a result of a motor vehicle accident? ❑ Yes ❑ No Is yes, please give the following details.

Date of accident __________________________________ Insurance Company _________________________

Name of Adjuster _________________________________ Claim # ___________________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy. Furthermore, I understand that the Chiropractor will prepare any necessary reports and forms to assist me in making collection for which there may be a normal fee charged to me.

Is this injury a Worker's Compensation Board claim? ❑ Yes ❑ No

If yes, what is your S.I.N. #? ________________________ and your NS Health Card #? ___________________

What is your claim number? ________________________

In the event of coverage resulting from a work related injury, a Worker's Compensation Board (WCB) claim number and confirmation of coverage must be obtained to proceed with direct billing. If not provided, or if the claim has not yet been approved, you will be personally responsible for all fees billed to your account. Once the claim is approved, it is your responsibility to advise the clinic of this. It is also your responsibility to submit your receipts for any treatments rendered prior to providing clinic staff with your claim number, to the WCB for reimbursement of the portion covered by the WCB. Any subsequent treatments would be billed directly to the WCB.

LaHave River Chiropractic and Health Centre

Health Questionnaire - Page 3

Emergency Contact________________________________ Tel ___________________ Relation _________________

Employer ____ Occupation ___________________________________

How did you hear about our clinic? ❑ Phone Book ❑ Web site ❑ Friend ❑ (who?) _________________________

❑ Advertisement ❑ Brochure ❑ Other ________________________________

Health Insurance - ❑ Yes ❑ No Name of Carrier _____________________________________ Policy # _________

Name of Family Doctor ____ Tel _______________

Address ____

Have you ever been treated by a Chiropractor? Yes No If yes, when?_____________________________________

Facility Name __________________________________ Doctor ____

Reason for treatment ____________________________ Results ____

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment at the time of the visit unless other arrangements with insurance companies have been made.

I am aware of the cancellation policy.

____ ____

Patient Signature Date

____

Guardian Signature (if patient is a minor)

CANCELLATION POLICY

Because your appointment time is time set aside for you, we ask that you respect our time and provide us with a minimum 24 hours notice if you have to cancel your appointment. This gives us time to schedule in someone from the waiting list. We reserve the right to charge the full visit fee for missed appointments.

Weather - The weather can be unpredictable in Nova Scotia. Our cancellation policy DOES NOT APPLY for weather related changes. We find it best to keep appointments scheduled as planned and see what the storm day brings. It is **not necessary** to change your appointment for a pending storm.

Illness or family emergency - These events cannot be predicted either and the usual 24 hour notice policy does not apply.

LaHave River Chiropractic and Health Centre

Health Questionnaire - Page 4

Patient Privacy Consent Form

For collection, Use, and Disclosure of Personal Information

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

All staff members who come in contact with your personal information are aware of sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we 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 protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Information Disclosure

Your personal information shall be disclosed to only those who have a need to know and the specific information disclosed shall be restricted to only that information relevant to the recipients' need to know. Those who have a need to know include other chiropractors and health care providers. Further, the personal information disclosed to benefit providers is limited to only that personal information required by the provider. You may at any time designate any restrictions as to whom we may disclose your personal information or restrict the content of a disclosure. Your information may be accessed by regulatory authorities under terms of the Chiropractic Act of Nova Scotia 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 that this kind of request is made, we will forward the information directly to you for your review, and for your specific consent. When unusual requests are received, we will contact you for your permission to release such information. We may also advise you if such a release is appropriate.** You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Contact or Complaint Process

Should you have any questions, comments, concerns, or complaints regarding our privacy practices, please do so in writing to our privacy officer, Dr. L. Cowie.

On occasion we may need to contact you regarding scheduling, cancellations, or other circumstances. Please check the appropriate boxes below for the following forms of acceptable communications:

- ❐ You may call me at home
- ❐ You may leave messages for me at home
- ❐ You may call my cell phone
- ❐ You may call me at work
- ❐ You may leave messages for me at work
- ❐ You may email me

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 know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that the **LaHave River Chiropractic and Health Centre** can collect, use, and disclose personal information about the mentioned person below as set out above in the information about the office's privacy policies.

________________________ ________________________ ________________________

Signature | Print Name | Date