



**QUARRY
CHIROPRACTIC
CLINIC**

416.699.0368
www.quarrychiropractic.com
info@quarrychiropractic.com

CHIROPRACTIC CARE

Service:	Fee:
Initial Consultation <i>including</i> first treatment	\$80.00
Chiropractic & Acupuncture Combo	\$55.00
Subsequent Visit	\$40.00
Acupuncture only	\$40.00
Re-evaluation re: 90+ days since last treatment	\$45.00
Orthotic Devices*	\$400.00
Orthotic shoes / sandals*	\$500.00
* 50% deposit required on all orthotic devices, shoes & sandals	

WE ACCEPT: CASH, CHEQUE, INTERAC, VISA, MASTERCARD

WSIB: yes / no Date of Accident: _____ WSIB Claim # _____

MVA: yes / no Date of Accident: _____

The Quarry Chiropractic Clinic does not third party bill (ie. Bill your insurance company on your behalf). Fees recoverable from extended health care plans are the patients responsibility.

Note: If more than 3 appointments are missed without notifying the office, you will be charged \$40 for a missed visit along with your next treatment fee.

Extended Health Care Benefits

We want to help create a plan that will maximize your benefits and prevent you from exceeding what is covered by your plan as best as possible. Do you know what your coverage is for:

Chiropractic Care:

Acupuncture:

Physiotherapy :

Naturopathic Medicine:

Registered Massage Therapy:

Custom Orthotic Devices/Shoes:

Other:

Date: _____ **Signature:** _____

The data on this confidential form is essential if we are to tender the best professional care. We appreciate your co-operation in filing it out so that we will have accurate records. PLEASE PRINT CLEARLY – THANK YOU

Name: _____ Sex: M / F

Home address: _____

City / Town: _____ Postal code: _____

Home Phone: _____ Business: _____

Cell / Pager _____ Referred by: _____

Email address: _____ Occupation: _____

Date of Birth: day: _____ month: _____ year: _____

Medical Doctor: _____ phone #: _____

PLEASE INITIAL IF YOU CONSENT TO COMMUNICATIONS BETWEEN YOUR CHIROPRACTOR AND MEDICAL DOCTOR: _____

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Visit

Is this visit due to a Motor Vehicle Accident (MVA)? Yes No

Is this a WSIB case and has it been reported to your employer? Yes No Are you in pain: Yes No

Rate your pain with the following scale: Low Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: Work Sports / Play Auto Accident Routine / Household Activity

When did your condition / accident occur? _____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and goes

Is your condition interfering with your; Work Sleep or Daily routine? If so, how: _____

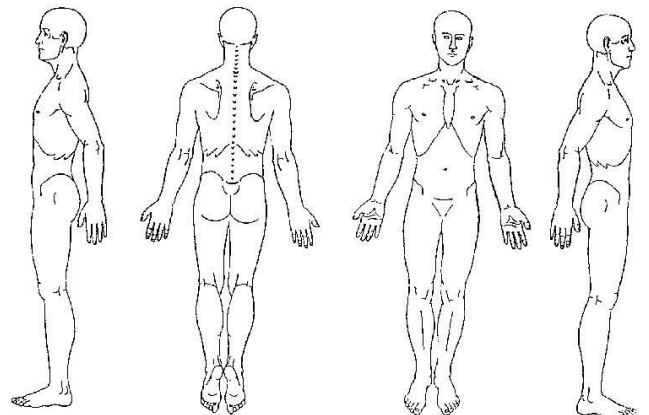
Has this or something similar happened in the past?
 Yes No Explain: _____

Using the adjacent body charts, please circle all affected Areas.

Have you been treated by a medical physician for this Pain? Yes No

Have you ever been treated by a chiropractor? Yes No

Clinic or Dr's Name: _____



Left

Back

Front

Right

Are you taking any of the following medications? Nerve Pills Pain killers (including aspirin) Muscle relaxes Blood thinners
 Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/ Stroke	Y N Heart/ Surg./ Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol/ Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N Anemia/ Diabetes
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Kidney Problems
Y N High/ Low Blood Pressure	Y N Psychiatric problems	Y N Rheumatic Fever	Y N Severe/ Frequent Headaches	Y N Tuberculosis
Y N Ulcers/ Colitis	Y N Fainting/ Seizures/ Epilepsy	Y N Sinus Problems	Y N Emphysema/ Asthma	Y N Arthritis
Y N Difficulty Breathing	Y N Birth Control Pill	Y N Lower Back Problems	Y N Artificial Bones/ Joints/ Implants	Y N Allergies
Y N Are you pregnant	How many weeks ? _____	Y N Anticoagulants	Y N Hemophiliac	

Please list any surgeries with dates and/ or any other serious medical condition(s) not listed above:

List any past serious accidents with dates:

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand the benefits of collaboration between my health care providers. If I were to be under the treatment/care of more than one staff member of the Quarry Chiropractic Clinic, then I authorize collaboration between parties to provide me with the best care possible.

Signature _____ Date _____

Adult patient Parent or Guardian Spouse

Consent to Chiropractic Treatment Form

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation on symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

This consent form applies to all chiropractors at this clinic.

Dated this _____ day of _____, 20_____

Patient Signature (Legal Guardian)

Patient Name: Please Print

Witness Name: Signature

Witness Name: Please Print

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture and as needed other procedures by Dr. Leah Gibeault and other associates within the clinic that are licensed to practice acupuncture.

I understand that in the practice of acupuncture there are some risks including, but not limited to, minor bleeding/bruising, minor soreness, nausea, fainting, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles are used, which are disposed of after each use/treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the Doctors to exercise judgment during the course of treatment, which based on the facts then known, is in my best interest. I understand that the results are not guaranteed.

I have read the above consent form. I have had an opportunity to ask questions and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions and extend this consent to the acupuncture colleagues within this clinic.

Note: Female patients: I fully understand that in case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible.

_____ I hereby state that I am **not** pregnant
nor any possibility that I may be pregnant

_____ I hereby state that I **am** pregnant

Dated this _____ day of _____, 20_____

Patient Signature (Legal Guardian)

Patient Name: Please Print

Witness Name: Signature

Witness Name: Please Print

Acupuncture in conjunction with any other treatment is an additional \$15

Please note: this form is to be re-signed every 5 years

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