NOVO HEALTHNET LIMITED

CHIROPRACTOR HEALTH HISTORY QUESTIONNAIRE

DATE OF ASSESSMENT: _____

NAME: _____ DOB: _____

HOW & WHEN DID THIS START? _____

_____

HAS THIS HAPPENED BEFORE? _____

IS THE PAIN LOCAL TO THE AREA OR DOES IT TRAVEL? _____

PLEASE IDENTIFY THE SEVERITY OF THE PAIN? Choose Between 0 and 10

DESCRIBE THE PAIN: (sharp, dull, aching, burning, other)

_____

WHAT AGGRAVATES YOUR COMPLAINT? _____

WHAT RELIEVES YOUR COMPLAINT? _____

HAVE YOU RECEIVED ANY CHIROPRACTIC/PHYSIOTHERAPY/MASSAGE THERAPY TREATMENTS FOR THIS COMPLAINT? _____

HAVE YOU RECEIVED ANY MEDICAL TREATMENT FOR THIS COMPLAINT? _____

HAVE YOU HAD ANY PREVIOUS TRAUMA OR ACCIDENTS? _____

_____

ANY UNEXPLAINED WEIGHT LOSS?

BLADDER / BOWEL PROBLEMS?

FEVER OR NIGHT SWEATS?

CAN YOU SLEEP THROUGH THE NIGHT?

DO YOU HAVE A FAMILY HISTORY OF:

HEART DISEASE ☐ CANCER ☐

ARTHRITIS ☐ DIABETES ☐

OSTEOPOROSIS ☐ OTHER _____

ARE YOU ON ANY MEDICATION? _____

DO YOU HAVE ANY ALLERGIES? _____

ANY PREVIOUS SURGERIES? _____

_____

HOW MANY HOURS OF PHYSICAL ACTIVITY DO YOU PERFORM PER WEEK? _____

IS THIS CONDITION PREVENTING YOU FROM DOING ANYTHING? _____

_____

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CHIROPRACTOR HEALTH HISTORY QUESTIONNAIRE

THE INFORMATION RECEIVED IS CONFIDENTIAL AND USED FOR THE PURPOSE OF ENHANCING YOUR CARE.

NAME: _____ TODAY'S DATE: _____

DOB: _____ HOME PHONE: _____

ADDRESS: _____ CELL PHONE: _____

_____ EMAIL: _____

MARITAL STATUS: (CIRCLE ONE) SINGLE ☐ MARRIED ☐ COMMON LAW ☐ DIVORCED ☐ WIDOWED ☐

EMERGENCY CONTACT: _____ PHONE: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US? _____

IS THIS A RESULT OF A MOTOR VEHICLE ACCIDENT?

CLAIM #_____

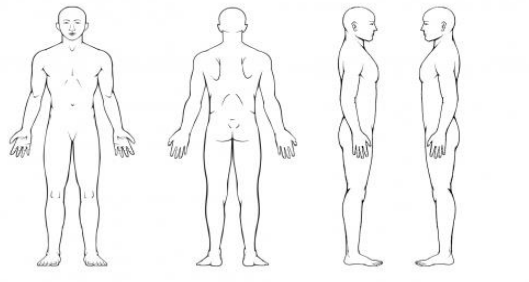
DATE OF INJURY: _____

IS THIS A RESULT OF A WORK PLACE INJURY?

CLAIM#_____

INSURANCE CONTACT: _____

PRIMARY COMPLAINT: _____



PLEASE CIRCLE ALL AREAS OF COMPLAINT ABOVE

DO YOU SMOKE? PER WEEK: Choose One

DO YOU DRINK ALCOHOL? PER WEEK: Choose One

OCCUPATION: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU.

☐ HEADACHES	☐ FLUSHED FACE	☐ BACK PAIN	☐ NECK PAIN	☐ STIFF NECK
☐ DIZZINESS	☐ NUMBNESS	☐ IRRITABILITY	☐ FATIGUE	☐ PINS & NEEDLES
☐ COLD HANDS/FEET	☐ DEPRESSION	☐ RINGING IN EARS	☐ LOSS OF BALANCE	☐ ANXIETY
☐ SENSITIVITY TO LIGHT	☐ SLEEPING PROBLEMS	☐ MEMORY LOSS	☐ LOSS OF SMELL OR TASTE	☐ ACID REFLUX
☐ NAUSEA / VOMITING	☐ DIARRHEA	☐ CONSTIPATION	☐ SHORTNESS OF BREATH	☐ CHEST PAIN

NOVO HEALTHNET LIMITED

CONFIDENTIAL CONSENT, AUTHORIZATION & DIRECTION TO DISCLOSE PERSONAL INFORMATION

I, _____
(Print Full Name)

Of_____
(Print Full Address)

Hereby consent to the sharing and / or exchange of written and/or verbal information between Novo Healthnet Limited and:

_____

_____

_____
(Print full names and institutions of affiliation)

In respect of

_____
(Print name of the client)

_____
(Date of birth)

Information to be released related to the above-named injury or illness and pertains to the development of treatment and nutritional plans.

I understand that this consent is subject to revocation at any time, except for such action that has already been taken.

A photocopy of this authorization shall have the same validity as the original.

Dated the _____ day of _____, 20____

_____ _____

(Witness) **(Signature)**

Cancelation Policy

DATE: _____

Name: _____ DOB: _____
DOL: _____ Claim #: _____

We understand that unplanned issues may come up and you will need to cancel an appointment. If this happens, we respectfully ask that you notify us at least 24 hours prior to your appointment time.

Our therapists want to be available to meet your needs as well as the needs for all of our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.

If we are not provided with the appropriate notice, you will be responsible for a Missed Treatment charge of $50.00. For any Missed Massage Treatment, you will be charged in accordance with the RMTAO as follows: 2nd missed massage – 50% of the massage fee / 3rd missed massage – 100 % of the massage fee.

This charge will not be billed to any third-party payors, you will be billed, and it must be paid by you for you to continue to be treated under your claim. Under certain circumstances management may waive this fee.

By signing below, you understand and agree to the cancelation and payment policy.

_____ _____
Patient's Name Witness Name

_____ _____
Patient's Signature Witness Signature