



Beyond the Next Level
New Patient Health Questionnaire

First Name: _____ Last Name: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Which is the best way to reach you? _____

Birth Date: _____

Family Medical Physician: _____

May we contact your Physician regarding your treatment and progress at this clinic? Yes No _____
Signature

If this is a sports injury, may we consult with your coach/trainer regarding your progress? Yes No _____
Signature

Name of coach: _____

Phone: _____

Team: _____

How did you hear about our office?

Friend/Family Sign Coach/Trainer Please Specify: _____

What is the reason you are seeking treatment?
Sports Injury Work Injury Automobile Injury Chronic/Ongoing Injury Other _____

Please describe your complaint: _____

How long has it bothered you? (please provide date if possible) _____

Describe how your problem began: (ie: fall, collision) _____

Are your symptoms:
Increasing not changing decreasing

Is this a:
new problem old problem recurring problem

What activities make your problem better?

What activities make your problem worse?

Which of the following decrease your discomfort:
Ice Heat Stretching Anti-Inflammatories
Nothing Other _____

Please draw in the area of your pain:

The diagrams show a human figure from the front, back, front with arms outstretched, and side view. The back view shows the spine and ribcage. The front view with arms outstretched shows the chest and shoulder area. The side view shows the profile of the body.

Beyond the Next Level

Sports Medicine and Training Centre

2300 Cornwall Rd, Oakville, ON

905-845-6989 ext 265

Beyond the Next Level is an injury treatment and rehabilitation centre. All forms of treatment including Acupuncture, Rehabilitation, Chiropractic Adjustments, and Active Release Techniques (ART) fall under the scope of Chiropractic.

Most extended health plans cover Chiropractic services, but it is up to each individual to investigate these policies. From time to time x-rays may be required, in some cases a fee will be charged for these x-rays and/or the Radiologist's fee for reading them.

In the case of a hockey injury, Hockey Canada covers \$500.00 per calendar year for Chiropractic services. These fees must be paid to BTNL and retrieved from Hockey Canada following treatment.

Missed Appointments

Our company policy is that missed sessions or cancellation without 24 hours notice will result in a \$35 charge for the missed session.

Service	Adult Fee	Student Fee
Initial consultation including treatment	85.00	80.00
Treatment	45.00	40.00

Most treatments at this clinic involve forms of deep tissue therapy, rehabilitation, and forms of Physical Therapy modalities. However, in some cases acupuncture and/or chiropractic adjustments may be warranted. For this reason, I am required to present the following consent form by the College of Chiropractors of Ontario.

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short-term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Signature of Patient or parent guardian

Informed Consent for Acupuncture Care

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture as necessary including moxibustion cupping and or electroacupuncture by the above named doctor or another duly authorized doctor in the clinic

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

I have been advised that only pre sterilized needles will be used All acupuncture needles are properly disposed of after each and every 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 doctor to exercise judgment during the course of the treatment which the doctor feels at the time based upon the facts then known is in my best interests

I understand that the results are not guaranteed I have read the above consent form I have also had an opportunity to ask questions about its content 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 for which I seek treatment

Female Patients

I fully understand that in the case of pregnancy a risk of causing fetal distress with acupuncture treatment s is possible **I hereby state that I am not pregnant nor is there any possibility that I may be pregnant**

Print Patients Name

Signature of Patient or parent guardian

Date Signed