

**SOUTH POINT CHIROPRACTIC**  
**PATIENT INTRODUCTION FORM**  
**& CLINICAL RECORD**

Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Marital Status: S M W D  
(last) (first) (middle)

Date of Birth: \_\_\_\_\_ Home phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Office phone: \_\_\_\_\_

Occupation or Profession: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse's name: \_\_\_\_\_

Number of children: \_\_\_\_\_ Referred to this office by? \_\_\_\_\_

Have you had chiropractic care before? \_\_\_ By whom? \_\_\_\_\_ Last visit: \_\_\_\_\_

Do you have reason to believe that you may be pregnant? No \_\_\_ Yes \_\_\_ Due Date: \_\_\_\_\_

Are you claiming under W.C.B.? No: \_\_\_ Yes: \_\_\_ Claim # \_\_\_\_\_

Are you claiming under I.C.B.C.? No: \_\_\_ Yes: \_\_\_ Claim # \_\_\_\_\_

Briefly describe your complaint: \_\_\_\_\_

**DO YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING? IF YES, MARK "X"**

- |   |  |
|---|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Sciatic             |
| <input type="checkbox"/> Head pains             | <input type="checkbox"/> Low back pain       |
| <input type="checkbox"/> Neck pain              | <input type="checkbox"/> Mid back pain       |
| <input type="checkbox"/> Shoulder blade pain    | <input type="checkbox"/> Pain in legs        |
| <input type="checkbox"/> Arm pain               | <input type="checkbox"/> Tingling in legs    |
| <input type="checkbox"/> Tingling in arms       | <input type="checkbox"/> Fatigue             |
| <input type="checkbox"/> Loss of balance        | <input type="checkbox"/> Irritability        |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Nervousness         |
| <input type="checkbox"/> Sinus troubles         | <input type="checkbox"/> Indigestion         |
| <input type="checkbox"/> Menstrual cramps       | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> High blood pressure |

Have you ever had a major falls, car accidents or injuries  Yes  No  
If yes, please explain (give month and year) \_\_\_\_\_

Have you had any surgery? Yes  No  If yes, please give type and date: \_\_\_\_\_

**We would like to welcome you to our office and explain our office fees.**

Initial Consultation	Free	<u>MSP</u>
Initial Examination	\$50.00 - \$ 70.00	\$30.00
Subsequent visit	\$ 45.00	\$20.00

Most Extended Health Benefits include chiropractic in their benefits package.

Exempt Patients: The B.C. Medical Services Plan will subsidize chiropractic office visits if the income of an individual does not exceed a certain level. Patients that meet this requirement will have a total of ten visits for chiropractic, physiotherapy, massage therapy, and non-surgical podiatry.

X-ray examination **is not covered** by the B.C. Medical Services Plan. **You are responsible for the x-ray fee** at the time the x-rays are taken.

Standard fee for routine x-ray examination full spine	\$60.00 to \$110.00
Extremity x-ray	\$35.00

Assignment of Medical Services Plan Benefits

I request that benefits payable to me under the Medical and Health Care Services Act for chiropractic services rendered by Dr. Prii be made payable in my name and mailed to the following address:

Mark T. Prii D.C. Chiropractic Corporation  
South Point Chiropractic  
#205 – 2828 152<sup>nd</sup> Street, Surrey B.C. V4P 1G6

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by Dr. Prii.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
Patient Signature (or Parent/Guardian)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year