

Robie at Spring Garden Chiropractic Clinic

Thank you for choosing us for all of your needs!!!

Dr. J. Bradley Lohrenz
5991 Spring Garden Road, Suite 103
Halifax, NS, B3H 1Y6
(902) 422-3279
Email: chiro.brad@ns.aliantzinc.ca

Last Name: _____ Address: _____

First Name: _____ Middle Initial: _____ Postal Code: _____

Birth Date: _____ Sex: _____
Day/Month/Year M/F

Home Phone: _____
Email: _____

Single Married Widowed Divorced Occupation: _____

Spouses Name: _____ Employer: _____

Number of Children: _____ Work Phone: _____ Cell: _____

Referred by: Spouse – Family – Friend – Other
Chiropractor – Sign – Yellow Pages
Mail Information – Medical Doctor
Name: _____

Have you had previous chiropractic care?
 Yes No When: _____
Who: _____

Health Card Number: _____ Other Insurance: _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including diagnostic x-rays, if necessary, on me by the doctor(s) of chiropractic practicing at **Robie at Spring Garden Chiropractic Clinic** and/or anyone working in this clinic authorized by the doctor(s) of chiropractic.

I have had an opportunity to discuss with the doctor(s) of chiropractic at the **Robie at Spring Garden Chiropractic Clinic** and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand the 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(s) to be able to anticipate and explain all risks and complications and I wish to rely on the doctor's (exercise of judgment during the course of the procedure which the doctor(s) feel at this time, based upon the facts then known, is in my best interest.

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 of my present condition and of any further conditions(s) for which I seek treatment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand the **Robie at Spring Garden Chiropractic Clinic** will prepare any reports and forms necessary to assist me in making collection from the insurance and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

or

Parent / Guardian's Signature: _____ Date: _____

-----PLEASE COMPLETE BACK OF FORM

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5991 Spring Garden Road, Halifax, NS

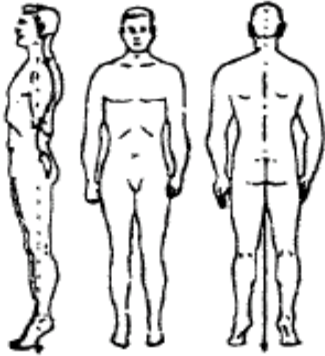
www.robiechiro.com

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Date: _____

Name: _____

Please mark area of major concern



Is this interfering with your

- work sleep enjoyment of life
 daily activities (gardening, vacuuming)
 other _____

Which activities aggravate your condition?

- bending lifting twisting sitting
 lying (side, back, stomach) standing coughing
 sneezing exercise stress
 other _____

When did the problem begin? _____

Previous care for this problem by: _____

Have you had this problem in the past?

When? _____

Have you had spinal x-rays? Yes No

When? _____

Where? _____

Is it getting: worse same better
Pains are: sharp dull constant intermittent

Have you ever suffered with any of the following:

- Diabetes Tuberculosis Lung Problems Fainting Cancer Asthma
 Stroke Heart Attack Epilepsy Hepatitis Psychological Disorder
 Fractures (Broken Bones) High/Low Blood Pressure Heart Disease
 Other Significant Problems _____

Have you ever been in an automobile accident? Yes No When? _____

Medications/Drugs you now use:

- Pain killers Blood Pressure Pills Birth Control Pills Muscle Relaxants
 Prednisone Antiinflammatory Blood Thinners Arthritic Pills
 Nerve Pills Antidepressants Other _____

List all surgical operations and years: _____

Other Symptoms:

- Headaches Back Pain Nervousness Tension Irritability
 Chest Pain Dizziness Flushed Face Stiff Neck Cold Hands
 Loss of Taste Loss of Smell Fatigue Depression Diarrhea
 Cold Feet Loss of Memory Ears Ring Neck Pain Constipation
 Numb Toes Stomach Upset Sleeping Problems Numb Fingers Short of Breath
 Pins and Needles in Legs Pins and Needles in Arms

Other significant trauma or symptom: _____