# Vibrant Life Healthcare

6105 Patricia Bay Highway
Victoria, BC, V8Y 1T4

Patient Name _____ _____ _____
(As it appears on your carecard) **LAST** **FIRST** **MIDDLE**

What name would you prefer us to use? _____

Address:_____ City:_____ Postal Code: _ _ _ - _ _ _

Date of Birth: _____ _____ _____ Age: _____ Gender: _____
**MONTH** **DAY** **YEAR**

Weight (lbs): _____ Occupation: _____

**Contact Information:**

Home #: _____
Cell #: _____
Work #: _____

E-mail Address: _____

*What is your preferred method of appointment reminders?*
□ Phone Call □ E-mail Reminder □ Text Reminder

**Emergency Contact:**

_____ _____ _____
**NAME** **PHONE #** **RELATIONSHIP**

*How did you hear about our office?*
☐ Driving By ☐ Internet ☐ Friend (who?_____) ☐ Other

**Are you on MSP Premium Assistance/Disability?** YES □ NO □
**Please note: There may be $23.00 coverage for Premium Assistance & Disability cases. The remaining portion is due on the date of service.**

**Were you injured at work?** YES □ NO □
**Do you have an active WCB claim?** YES □ NO □
**WCB claim#:**_____
* Please notify reception if you have not already if you have a WCB case

**Is this an ICBC case?** YES □ NO □
**ICBC Claim #:**_____
* Please notify reception if you have not already if you have an ICBC case

_____ _____
**Date of Initial Consultation** **Practitioner**

Please review the list of conditions and **check all that apply to you** (past or present). Be specific where necessary. All information is relevant in order to create a safe treatment plan for you.

**Musculoskeletal:**
- ☐ Headaches
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle spasm/cram
- ☐ Muscle strain
- ☐ Ligament sprain
- ☐ Fracture
- ☐ Dislocation
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Fibromyalgia
- ☐ Whiplash
- ☐ Other:

_____

**Digestive**
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Diverticulosis
- ☐ Ulcers
- ☐ Heartburn/ Acid reflux
- ☐ Other:_____

**Cardiovascular**
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart condition
- ☐ Pacemaker
- ☐ Stroke (CVA)
- ☐ Thrombosis (blood clot)
- ☐ Varicose veins/ Phlebitis
- ☐ Swelling
- ☐ Cold hands/feet
- ☐ Dizziness
- ☐ Poor circulation
- ☐ Clotting disorder
- ☐ Other:

_____

**Respiratory:**
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Other:

_____

**Family history of medical condition:**
- _____
- _____

**Nervous System:**
- ☐ Numbness/tingling
- ☐ Neuropraxia (nerve compression)
- ☐ Paralysis
- ☐ Cerebral Palsy
- ☐ Seizure disorder
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Spinal cord injury
- ☐ Head injury
- ☐ Herpes Zoster (Shingles)
- ☐ Other:

_____

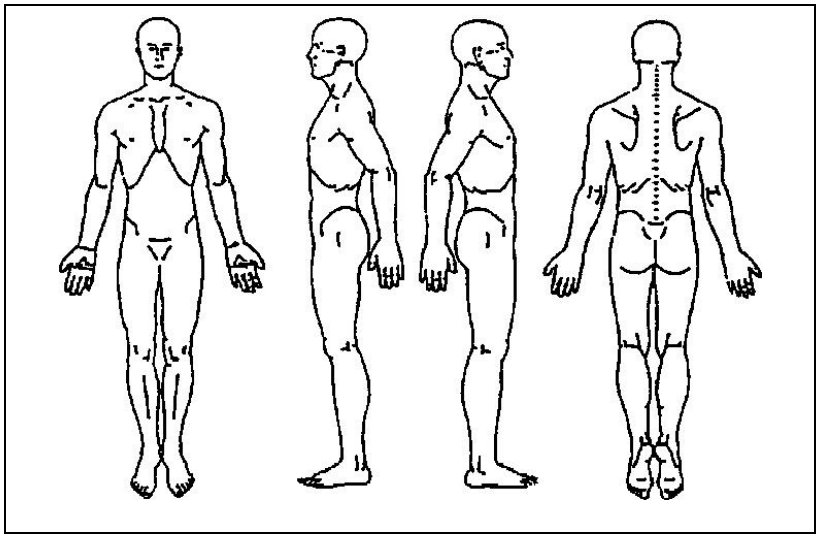
**Skin:**
- ☐ Rash
- ☐ Athlete's foot
- ☐ Ringworm
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Bruise easily
- ☐ Other:

_____

**Women Only:**
- ☐ Pregnancy- weeks:_____
- ☐ Menstrual difficulties
- ☐ Ovarian/Uterine disorders
- ☐ Breast issues

**Other:**
- ☐ Cancer:_____
- ☐ Diabetes- Type:_____
- ☐ Thyroid disease
- ☐ Impaired vision
- ☐ Impaired hearing
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue
- ☐ Sleep difficulties
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Hepatitis
- ☐ HIV
- ☐ Rods/Pins/Plates/ Shunts
- ☐ Implants:_____
- ☐ Other:

_____



**Please indicate on the diagram the nature of your symptoms, using the symbols indicated:**

Aching: OOO

Stabbing: XXX

Shooting/Referral: → → →

Numbness/tingling: **~~~**

Who is your family doctor?_____ Last Visit?_____

For what purpose? _____

Are you presently undergoing treatment for any condition? YES □ NO □ If so, what?

_____

Please list **all major accidents, injuries or surgeries** you've had with approximate date of occurrence:

_____

Please list **all medications** you are currently taking and what they are prescribed for:

_____

Please list any NON-prescription vitamins, minerals, or other supplements you are currently taking:

_____

Please list **all known allergies:**

_____

Have you received a therapeutic massage from a Registered Massage Therapist before? YES □ NO □
Have you received treatment from a Chiropractor before? YES □ NO □

# LIFESTYLE ASSESSMENT

NUTRITION

Do you eat 4 servings each of fruits and vegetables daily? YES □ NO □
How much water do you drink daily?_____
How often do you eat fast food(eg. Fries, burgers, pop, pizza etc.)?_____

How much alcohol do you drink per week? wine;_____ beer;_____ hard liquor;_____
Do you smoke cigarettes?_____ How many packs/week?_____ For how many years?_____
Do you have a history of substance abuse or alcohol abuse? YES □ NO □

**EXERCISE**

Briefly describe your exercise level (type of activity, frequency, intensity and duration):
_____

How many hours on average, do you sit daily? _____

**Psychosocial**

Rate the level of stress in your work life: Low___ Moderate___ High___ Severe___
Rate the level of stress in your personal life: Low___ Moderate___ High___ Severe___
Do you have daily stress reduction strategies? YES □ NO □
How many hours do you sleep on an average night? _____
Sleeping Position? Back___ Stomach___ Right Side___ Left Side___ Both Sides_____
How many pillows? _____ Do you feel rested when you wake? _____

***Please tell us what you want out of your experience here — what are your goals?***

_____

# Office Policies

Payment for examination and treatments are due on the day services are rendered. Your treatments or custom foot orthotics may be covered, or partially covered by ICBC, WCB, MSP or your Insurance Provider. If, for whatever reason, your coverage is denied, then *you are fully responsible for payment of all services rendered.*

- **Please allow us at least 24 hours notice if you are unable to keep your appointment.**
- **If you miss/no-show your appointment, you will be charged the full appointment fee.**

Because many people have allergies to perfumes and other scents, we ask that you refrain from wearing them while in our office.

I understand and agree to the above policies.

_____ _____

Print Name Signature of Patient

Date: _____

**Please check**

□ I, hereby, give consent to share my health history information among the Vibrant Life Healthcare professionals (within their respective scopes of practice) for the purpose of efficient use of clinical resources for the achievement of integrated healthcare for the intended purpose of interprofessional collaboration by all health providers for the overall benefit of my health.

# Assignment of Benefits

***Some insurance plans allow for direct billing. Please provide the following information so we can bill your plan directly, if applicable to you and keep your information on file.***

CARECARD #: _____

INSURANCE COMPANY NAME: _____

PLAN MEMBER NAME: _____

POLICY/GROUP NUMBER: _____

PLAN MEMBER ID #: _____

**If you have dual insurance through a spouse or family member, please provide the following:**

INSURANCE COMPANY NAME: _____

PLAN MEMBER NAME: _____

PLAN MEMBER DATE OF BIRTH: _____

POLICY/GROUP NUMBER: _____

PLAN MEMBER ID #: _____

I understand that the fees listed in this claim and/or future claims may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the service provider for the entire cost associated with this claim and/or future claims.

**I hereby assign my benefits payable from this claim and/or future claims to Vibrant Life Healthcare and authorize payment directly to them. Vibrant Life Healthcare may bill electronically or manually on my behalf.**

I understand that my insurance provider and/or a benefit plan sponsor including; MSP Premium Assistance, reserve the right to modify assignment privileges for specific benefits, benefit categories, specific service providers or service provider categories.

I hereby certify that the information provided in connection with this claim is true, accurate and complete. I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, pre-payment organization, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any records, knowledge or information concerning this claim or my health or the health of any insured member of my family as it may relate to this claim to release such information to my insurance provider and to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of the claim. A photocopy of this signed authorization shall be as valid as the original.

Plan Member's Signature: _____ Date: _____

# The Exchange of Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing, and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

**Authorization and Consent**

I authorize Vibrant Life Healthcare to collect, use, and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and/or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Plan Member's Signature: _____ Date: _____

# CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

## Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

## Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

## Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

## Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

**Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

**DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR**

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor