Dr. Mark Tran
103 – 3 Father David Bauer Drive
Waterloo, ON N2L 6M1
(519) 954-8850

NEW PATIENT FORM

Thank you for choosing Achieve Wellness Centre.

We provide quality chiropractic care. Treatment is provided by Dr. Mark Tran. Direct and open communication between you and chiropractor is very important. Please tell us if: you require someone other than your chiropractor to be present during your treatment, or if you feel uncomfortable with the touch aspects of chiropractic therapy.

Please tell us about yourself

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms ☐ Dr.

Gender: ☐ MALE ☐ FEMALE ☐ OTHER: _____

Last name: _____

First name: _____

Date of birth: Day: _____ Month: _____ Year: _____

Address: _____

_____ Apt #: _____

City: _____ Postal Code: _____

Phone: Home: (_____) _____ Work: (_____) _____

Email address: _____

Emergency Contact: _____ Phone: (_____) _____

What is your occupation: _____

Previous chiropractic experience

Previous chiropractor's name: _____

Previous chiropractor's telephone: _____

Date of last chiropractic visit: _____

Medical doctor's name: _____

Medical doctor's telephone: _____

I consent to allow Dr. Mark Tran to contact my medical doctor about my health care.

Patient: _____
Signature

Witness: _____
Signature

How did you hear about us?

We are pleased that you have chosen to come and see us! Please take some time to let us know how you found out about the Achieve Wellness Centre:

☐ Magazine ☐ Newspaper ☐ Internet ☐ Yellowpages
☐ Outreach Program ☐ Signage ☐ Friend or Relative

☐ Other: _____

Please turn over

Billing information

Health Insurance Information

Do you have extended healthcare insurance? ☐ Yes ☐ No
(If not, you do NOT need to fill in the following information)

Insurer's name: _____

Policy #: _____

Member #: _____

Type of injury

Is this a Workplace Safety & Insurance Board injury? ☐ Yes ☐ No
(If not, you do NOT need to fill in the following information)

What is your social insurance number? _____

WSIB claim number? _____ Date of accident: _____

Employer's name: _____

Employer's address and telephone: _____

Type of injury

Are your injuries related to a motor vehicle case? ☐ Yes ☐ No
(If not, you do NOT need to fill in the following information)

Date of accident: _____

Insurer's name: _____

Policy or claim #: _____

Insurer's address and telephone: _____

Consent

I agree and understand that I am responsible for all charges relating to my visit.

Date: _____ Signature: _____

Date: _____ Guardian: _____
If patient is under 18 years of age

Please note:

All accounts are the responsibility of the patient. Your supplemental or extended health care insurance plan may provide coverage for chiropractic services. We will issue a receipt for each payment for this purpose.

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Health Status Survey

Patient Name: _____ **File #:** _____
Date:_____

Please **check** √ the box for any conditions or symptoms **presently** causing you problems.
Please **X the box** for those conditions or symptoms **that you have had in the past**.

General Symptoms		Respiratory		Skin	
Loss of consciousness		Asthma		Rashes/itching	
Blackouts		Chronic cough		Bruise easy	
Headache		Spitting up phlegm		Dryness	
Fever		Spitting up blood		Boils	
Excess sweating		Difficulty breathing		Hives (allergies)	
Night sweats		Cardiovascular		Gastrointestinal	
Loss of weight		Bleeding disorder		Poor appetite	
Night pain		High blood pressure		Indigestion	
Generalized pain		Chest pain		Excess hunger	
Nervousness		Stroke		Belching or gas	
Convulsions		Hardening of arteries		Vomiting	
Loss of sleep		Varicose veins		Pain over stomach	
Neurologic		Swelling of ankles		Constipation	
Dizziness		Poor circulation		Diarrhea	
Fainting		Heart/blood disease		Hemorrhoids (piles)	
Problem speaking		Angina		Jaundice	
Problem swallowing		Genitourinary		Gall bladder trouble	
Blurred vision		Trouble urinating		Intestinal worms	
Double vision		Blood in urine		Ulcer	
Nausea		Kidney infection		Diabetes	
Clumsiness		Bedwetting		Have you ever had any fractures?	
Numbness or tingling		Prostate trouble		yes no	
Muscles and Joints		GU for Women		If yes - where?	
Sore/stiff neck		Painful menstruation		Have you ever been in a car accident?	
Mid back ache		Excessive flow		yes no	
Low back ache		Hot flashes		If yes - when?	
Painful tailbone		Irregular/absent cycle		Have you ever been hospitalized?	
Shoulder pain		Cramping/backache		yes no	
Arm/forearm pain		Vaginal discharge		Why/When?	
Elbow pain		Swollen breasts		Are you currently a smoker?	
Wrist/hand pain		Lump in breasts		yes no How much? _____	
Hip pain		Currently on birth control pills/patch?		Did you smoke previously?	
Knee pain		yes no		yes no How much? _____	
Ankle/foot trouble		Previously on birth control pills/patch?		Have you ever been diagnosed:	
Arthritis		yes no		With cancer? yes no	
Loss of strength		# of pregnancies ____		With HIV/AIDS? yes no	
Eyes/Ears/Nose/Throat		# of children ____		With Hep A/B/C? yes no	
Failing vision		Medications (list):			
Eye pain					
Failing hearing					
Earache		Clinician Comments:			
Ring/buzz in ears					
Frequent colds					
Sinus infection					
Enlarged thyroid					
Enlarged glands					

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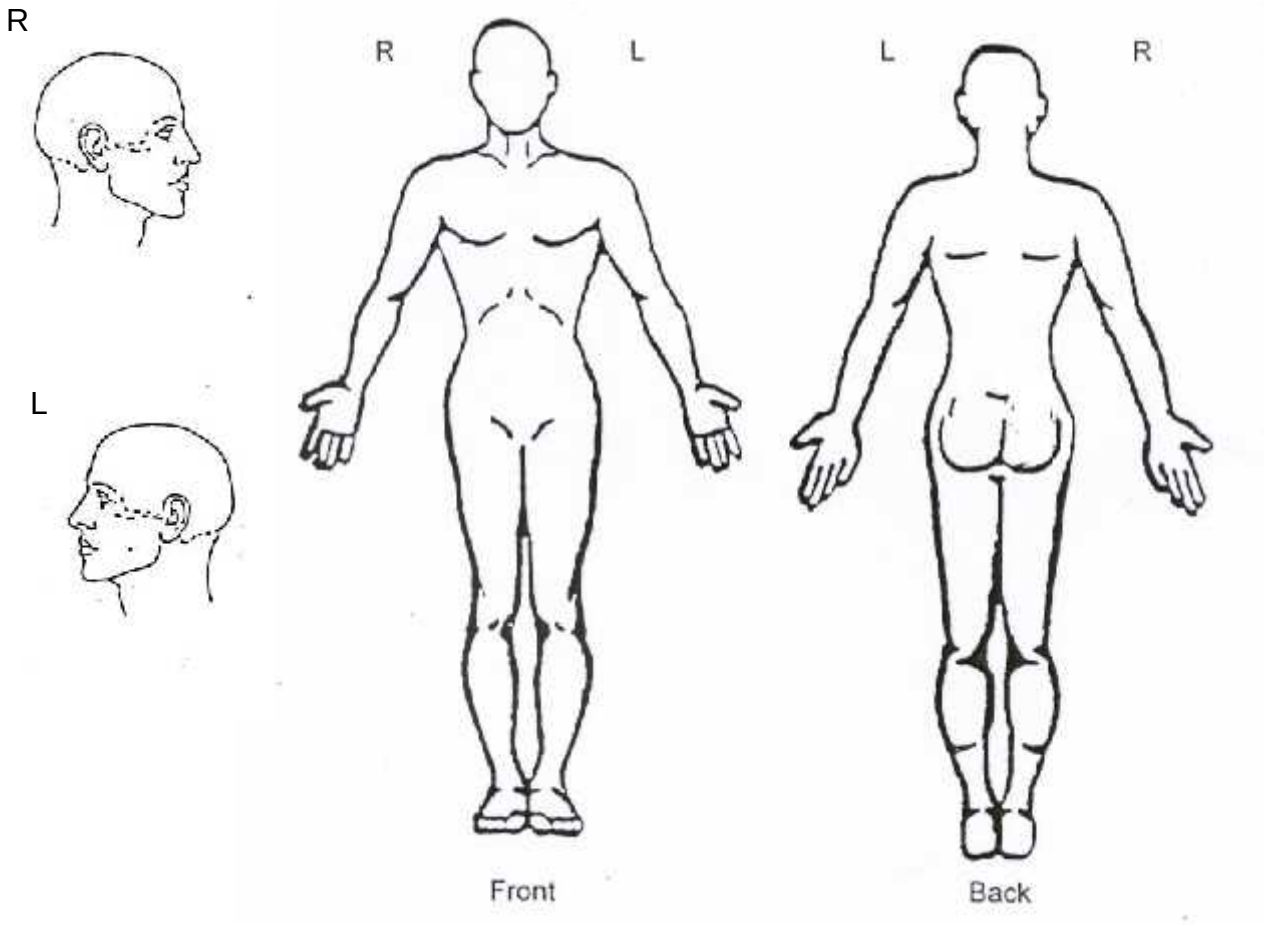
Symptom Diagram

Pt. Name: _____ File #: _____ Date: _____

In the diagrams provided below, please mark the areas on your body, which you feel best, represent the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below. Please draw in the face on the diagram.

Symbols:

Numbness	≡≡≡≡≡≡≡	Pins and Needles	**ooooo**
Burning	**x x x x x x**	Stabbing & Sharp	~~~~
Dull & Aching	**Δ Δ Δ Δ Δ Δ**	Stiff & Tight	**2 2 2 2 2**



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Privacy Code
Achieve Wellness Centre

Privacy of personal information is important to the Achieve Wellness Centre. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be as open and transparent as to how we handle personal information.

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; the health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and destruction of your personal information complies with existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario and the law.

Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, the clinicians that provide you with chiropractic services, the clinic administration and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinic uses and discloses this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- To complete and submit claims on your behalf to third party payors
- To comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts

Please turn over

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent

I have reviewed the above information that explains how the clinic will use my personal information. I know that the Achieve Wellness Centre has a Privacy Code and I may ask to see it at any time.

I agree that the Achieve Wellness Centre can collect, use and disclose my personal information as set out above in the clinic's privacy code.

_____

(Signature)

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_____

(Print Name)

_____

(Date)

_____

(Signature of Witness)