WELCOME

Thank you for choosing Chiropractic Care at Pinewood Natural Health Centre. We are honoured to work with you on your journey towards better health and optimal wellbeing.

Here's what we suggest you do before your first visit:

- To save time we suggest completing the Patient Information Form prior to your first visit. The form can be downloaded from the website or contact us to have it emailed/faxed to you. Completed forms may be emailed to ablumberg@pinewoodhealth.ca or brought with you to your visit. If you intend to complete the forms in person at the clinic, please arrive 10-15 minutes prior to your scheduled appointment.
- To facilitate accurate saliva pH testing if necessary, please abstain from eating or drinking anything but water for 1 hour before your first appointment.
- Congratulate yourself on taking the first proactive step towards taking control of your improved health and to creating your own superb health and wellbeing!

Here is what you can expect from us on your first visit and beyond:

- Your 1st visit will take approximately 45 minutes
- After carefully reviewing your Patient Information Form, Dr. Blumberg will meet with you for a personal consultation. This is the time to clarify the concerns that brought you to our office, your health history, and your health goals.
- With your permission, Dr. Blumberg will then perform a comprehensive examination which may include an assessment of your posture, balance, range of motion, strength, and nervous system function. The exam may also include two computerized neurological scans, a pH saliva test and a referral for x-rays if indicated.
- Dr. Blumberg will use the time between your 1st and 2nd visits to review your case and put together a detailed Doctor's Report of Findings package for you that will outline the health of your nervous system, and recommendations for your care, and provide you with further information.
- On your second visit, you will receive your Report of Findings and have an opportunity to review your x-rays and wellness recommendations with your doctor
- We will then work together to plan out your appointment and fee schedule to make your office visits effortless and get you started on your path to a healthier lifestyle!

Here's what we ask from you:

- Payment is expected at the time of service. It is important to us that our financial arrangement be clear. It is our desire to support you in any way we can to meet your financial obligations while you make a choice toward more perfect health.
- Your customized treatment program will be designed so that you may achieve maximum correction in the shortest amount of time. Adhering to the treatment schedule prescribed assists you in getting better faster and staying well longer. We understand that unforeseen circumstances occur. If you have to cancel an appointment please give us 24 hours notice and reschedule promptly to stay on track. Repeated short-notice cancellations will result in a $25 cancellation fee being applied to your account.
- No question should ever go unasked or unanswered. Dr. Blumberg prides herself on developing a unique and personal partnership with every patient. If you have any questions about your involvement with our clinic, do not hesitate to contact Dr. Blumberg directly at 416-613-9355 or ablumberg@pinewoodhealth.ca.

PATIENT INFORMATION FORM

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (C) _____ Which # do you prefer we use? _____

Email Address: _____ May we add you to our mail/email list? Y ___ N __

Date of Birth (dd/mm/yy): _____ Gender: _____ Marital Status _____ # of Children ____

Occupation: _____ Employer: _____

Emergency Contact Name and Phone Number: _____

Who may we thank for referring you to us? _____

HEALTH HISTORY

Did you have any childhood illnesses? _____ Explain: _____

Have you had any surgeries/hospitalizations? _____

Were you involved in any car accidents? _____ Explain: _____

Have you suffered any other physical trauma? _____

If this visit relates to a physical complaint: When did symptoms/accident happen? _____

Are you taking any medication? _____ If yes, list _____

Date of last physical examination _____ Doctor's Name _____

Have you seen a chiropractor before? _____ When was your last visit? _____

Do you or any close family members suffer from any of the following?

❑ Allergies	❑ Bloating	❑ Epilepsy	❑ Hormone imbal.	❑ P.M.S	❑ Tendonitis/Bursitis
❑ Aneurysm	❑ Cancer	❑ Fatigue	❑ Indigestion	❑ Respiratory Condition	
❑ Arthritis	❑ Diabetes	❑ Heart condition	❑ Intestinal disorder	❑ Stroke	❑ Weak Immunity
❑ Asthma	❑ Disc prob.	❑ High Blood Press.	❑ Osteoporosis	❑ Skin Cond.	

The following can be signs of nervous system problems. Please check off all that you currently have or have previously experienced: (O = Occasional F= Frequent C= Constant)

O F C	O F C	O F C	O F C
❑ ❑ ❑ Headaches	❑ ❑ ❑ Buzz/Ring in ears	❑ ❑ ❑ Problems urinating	❑ ❑ ❑ Nervousness
❑ ❑ ❑ Pins/Needles	❑ ❑ ❑ Visual problems	❑ ❑ ❑ Diarrhea/Constipation	❑ ❑ ❑ Irritability
❑ ❑ ❑ Dizziness/Fainting	❑ ❑ ❑ Loss of taste/smell	❑ ❑ ❑ Menstrual pain/Irreg	❑ ❑ ❑ Mood Swings
❑ ❑ ❑ Cold extremities	❑ ❑ ❑ Allergies/Asthma	❑ ❑ ❑ Sleep prob./Fatigue	❑ ❑ ❑ Depression
❑ ❑ ❑ Loss of balance	❑ ❑ ❑ Stomach Tension/Ulcer	❑ ❑ ❑ Neck/Back Pain	❑ ❑ ❑ Numbness

Dr. Alisa Blumberg – Pinewood Natural Health Centre
110-220 Duncan Mills Rd., Toronto, Ontario, M3B 3J5, (416) 656-8100, ablumberg@pinewoodhealth.ca

Patient Name:_____

CURRENT HEALTH CONDITION

Purpose of this appointment (wellness/prevention/symptom relief)? Briefly describe _____

_____

Compare this problem at its worst to when you feel great. How does it affect your ability to work? Your ability to enjoy your family and social time? Your ability to enjoy hobbies and sports?_____

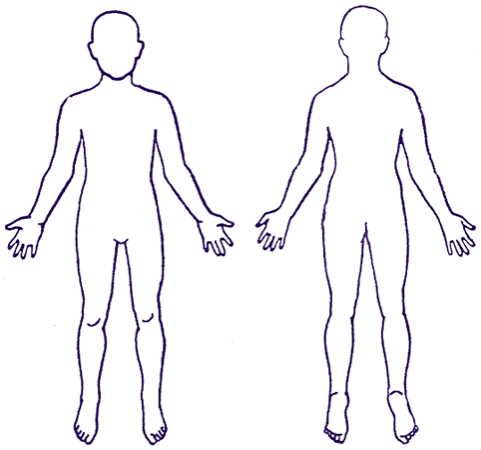
_____

Have you ever had a similar condition? _____ If yes, when and describe: _____

Why do you feel your body has not healed itself of this problem? _____

Other doctors seen for this condition: _____

PHYSICAL WELLBEING



Please use the following letters to represent on the diagram the areas that bother you. (example, if your hand is numb put an N over the hand in the drawing)

N – numbness
P – pain
T – tingling
A – ache
S – soreness
ST - stiffness

Please rate your current discomfort by marking an X on the line below:

NONE _____WORST IMAGINABLE

Please rate your level of stress with an X on the line: NONE _____WORST IMAGINABLE

Please rate your level of happiness with an X on the line: NONE _____ HAPPIEST

Have you experienced psychological pain from feelings of depression, nervousness, irritability? _____

How many hours of sleep do you get per night? ____ Do you wake up feeling rested? _____

How many days per week do you meditate? _____

GOALS

Total wellness involves much more than physical health. Are there any areas/circumstances in your life in which you haven't yet achieved your goals (ex. relationship, financial)? _____

_____

Patient Name:_____

CHEMICAL BALANCE

Speed of healing is determined by chemical balance in the body. Chemical balance is determined, in large part, by what you eat. Please indicate the amounts and frequencies you partake of the following (BE HONEST!):

	Per Day	Per Week
1. Coffee (caff/decaff)	____ cups	____ cups
2. Tea (herbal/regular)	____ cups	____ cups
3. Sugar, sweets, desserts, candy, artificial sweetner	____ times	____ times
4. Salt, salty snacks, chips, etc.	____ servings	____ servings
5. Do you add salt to food at mealtime?	____ yes ____ no ____ occasionally	
6. Red meat (beef, pork, bacon, ham etc.)	____ servings	____ servings
7. Chicken/fish	____ servings	____ servings
8. Dairy (milk, cheese, ice cream etc.)	____ glasses/times	____ glasses/times
9. Water	____ glasses	____ glasses
10. Fresh fruit	____ servings	____ servings
11. Fresh vegetables (non-canned)	____ servings	____ servings
12. Alcoholic beverages	____ servings	____ servings
13. Soft drinks (caff/decaff)	____ servings	____ servings
14. Smoking	____ packs	____ packs

What is a typical breakfast for you? _____

What is a typical lunch for you? _____

What is a typical evening meal for you? _____

List any vitamins/herbs you are currently taking _____

Patient Name:_____

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 and 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 the 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 my present and future chiropractic care.

Dated this _____ day of _____, 20 ____.

_____ _____

Patient Signature (Legal Guardian) Witness of Signature

Name: _____ Name: _____

(please print) (please print)

FEES POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that I will be financially responsible for all collection/legal fees incurred for the collection of any unpaid balance. I understand that a $25 fee may be applied to my account if I do not provide 24 hours notice of cancellation of my appointment.

Patient Signature: _____ Date: _____

Privacy Information Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, the Privacy Information Officer is:

Michael Rahman N.D.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses and Discloses patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services
- To communicate with other treating health-care providers, including specialists and referring doctors
- To allow us to maintain communication and contact with you to distribute healthcare information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act

- To comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the practice.
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To prepare materials for the Health Professions Appeal and Review Board (HPARB).
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirement
- To comply generally with the law

By signing the consent section of this Patient Consent 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.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the code at any time.

I agree that Pinewood Natural Health Centre can collect, use and disclose personal information about

_____ as set out above in the information about the office's privacy policies.
(Patient's Name)

Signature _____

Print Name _____

Date _____ Witness _____

☐ This consent was discussed and any questions or concerns have been addressed. _____
Primary Doctor's Signature

Privacy Information Sheet

How to Access the Privacy Process in Our Office

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your information.

Our privacy information officer can be reached at:

Pinewood Natural Health Centre
220 Duncan Mill Road, Unit 110
Toronto, ON
M3B 3J5
416 656-8100 (tel)
416 656-8107 (fax)
email: toronto@pinewoodhealth.ca

Our privacy information officer will attempt to answer any questions or concerns that may arise. If you have a concern and/or wish to make a complaint to us about our privacy practices, including asking questions about the contents of your charts or records, you must make your request in writing. Please send it to our office's Privacy Information Officer by surface mail, fax, or email.

Our Privacy Information Officer will promptly acknowledge receipt of your complaint in writing, and will ensure that it is investigated thoroughly. You will be provided with a formal decision in writing, and the reason for the decision. If you are dissatisfied with the decision, you may seek further information from the Privacy Commissioner of Canada. We have included all the necessary contact information listed below.

Postal Address:
Privacy Commissioner of Canada
112 Kent Street
Ottawa, ON K1A 1H3

General Inquiries:
Phone: 613-995-8210
Toll Free: 1-800-282-1376
Fax: 613-947-6850

Our privacy policies and procedures comply with federal legislation called the Personal Information Protection and Electronic Documents Act (PIPEDA). This very complex law does provide some exceptions to the privacy principles that are too detailed to outline here. Our privacy code sets out this office's commitment to protecting your private health and personal information. It is available on request by asking any of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.