

APPT. DATE

REFERRED BY

01 • PATIENT INFORMATION

NAME (FIRST, MIDDLE, LAST)

PREFERRED NAME

DATE OF BIRTH

SEX ☐ M ☐ F

AGE

EMPLOYER

OCCUPATION

MARITAL STATUS

☐ Married☐ Common-law☐ Divorced☐ Widowed☐ Engaged☐ Single

SPOUSE / SIGNIFICANT OTHER

CHILDREN – NAMES AND AGES

CONTACT

ADDRESS

CITY

POSTAL CODE

HOME PHONE

CELL PHONE

WORK PHONE

EMAIL

PREFERRED CONTACT

☐ Phone call☐ Text☐ Email

IN CASE OF EMERGENCY

EMERGENCY CONTACT

RELATIONSHIP

EMERGENCY PHONE

FAMILY PHYSICIAN

02 • CHIROPRACTIC HISTORY

Seen a chiropractor before? ☐ Yes ☐ No WHEN

REASON SEEN

Were you helped? ☐ Yes ☐ No

03 • HEALTH SUMMARY – CHECK ALL THAT YOU HAVE EVER HAD

☐ Headaches☐ Cold sweats☐ Menstrual irregularity☐ Neck pain / stiffness☐ Pins/needles in arms☐ Mood swings/irritability☐ Back pain☐ Loss of balance☐ Pins/needles in legs☐ Loss of smell☐ Ringing in ears☐ Nervousness☐ Asthma☐ Sinus / allergies☐ Loss of taste☐ Stomach upset☐ Numbness in fingers☐ Numbness in toes☐ Ulcers☐ Tension☐ Fatigue☐ Depression☐ Fainting☐ Cold feet☐ Sleeping problems☐ Arthritis☐ Diabetes☐ Hot flashes☐ Diarrhea☐ Frequent colds / flus☐ Cold hands☐ Heartburn☐ Constipation☐ Lights bother eyes☐ Problem urinating

OTHER PROBLEMS

04 • MEDICATIONS

List any medications you are taking and the reason for each.

PATIENT / GUARDIAN SIGNATURE

DATE

Family patterns can point to spinal and neurological concerns before they become symptoms. For each condition, mark **C** if a family member has it now, **P** if they had it in the past, or **D** if they are deceased. Leave blank if it does not apply.

CONDITION	FATHER	MOTHER	SPOUSE	SIBLING(S)	CHILD(REN)
Age					
Allergies					
Anxiety					
Arthritis					
Auto accidents					
Back pain					
Cancer					
Constipation					
Diabetes					
Disc problems					
Epilepsy					
Frequent colds / flus					
Gassy / bloating					
Headache					
Heartburn					
Heart trouble					
High blood pressure					
Low energy					
Migraine					
Neck pain					
Nervousness					
Pinched nerve					
Scoliosis					
Sinus trouble					
Sleeping problems					
Other _____					
Other _____					

05 • INSURANCE AND BILLING

INSURANCE PROVIDER

POLICY / CERTIFICATE #

GROUP #

POLICY HOLDER, IF NOT PATIENT

RELATIONSHIP TO PATIENT

☐ I authorize Nova Chiropractic and Wellness to submit claims directly to my insurer and to release the information needed to process them. I understand I am responsible for any portion my insurer does not cover.

SIGNATURE

DATE

06 • HEALTH AND SAFETY SCREENING

Answering yes does not rule out care — it helps Dr. Jelic plan your exam safely.

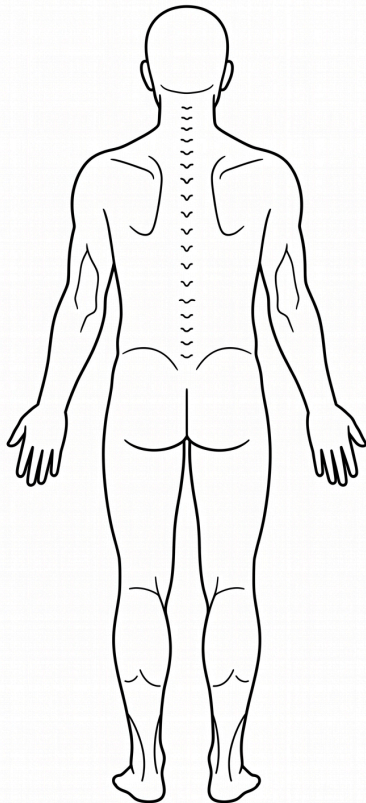
Currently pregnant?	☐ Yes ☐ No	Unexplained weight loss, last 3 months?	☐ Yes ☐ No
Numbness in saddle area, or bowel/bladder changes?	☐ Yes ☐ No	Recent major trauma, fall, or fracture?	☐ Yes ☐ No
Fever or chills with your back or neck pain?	☐ Yes ☐ No	History of cancer?	☐ Yes ☐ No
Taking blood thinners?	☐ Yes ☐ No	Diagnosed with osteoporosis?	☐ Yes ☐ No
Long-term steroid use?	☐ Yes ☐ No		

07 • PAIN LOCATION

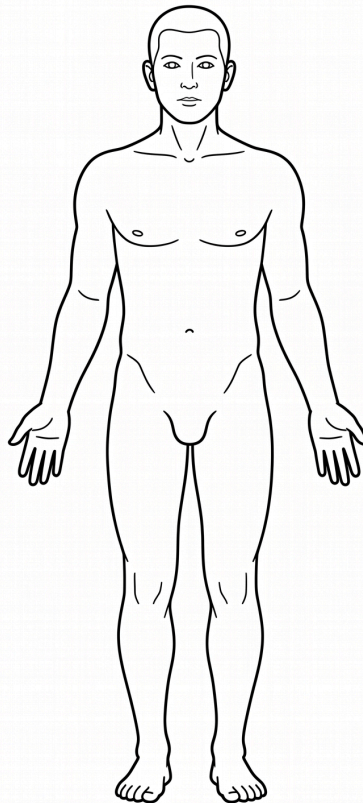
Draw where you feel it, using the marks below.



LEFT SIDE



BACK



FRONT



RIGHT SIDE

Ache ^^^^

Burning ====

Numbness oooo

Pins and needles

Stabbing ////

Other xxxx

08 • CONSENT TO EXAMINATION AND TREATMENT

CONSENT FOR EXAMINATION

The purpose of this examination is to assess your health history, musculoskeletal function, and neurological status in order to determine whether chiropractic care is appropriate for your condition, identify any contraindications to treatment, and develop a safe plan of care. Without a thorough examination, Dr. Jelic cannot accurately diagnose your condition or responsibly recommend treatment.

Your examination will be conducted by Dr. Dejan Jelic, D.C. (CCO Reg. No. 8207). If any other regulated health professional participates, you will be informed of their name and professional status in advance.

The examination may include a health history interview, postural and gait assessment, range of motion and functional testing, orthopedic and neurological testing, spinal and extremity palpation, and diagnostic imaging if clinically indicated. Each component will be explained before it is performed, including where you will be touched and any gowning required. Explicit verbal consent will be obtained before any contact with sensitive areas of the body. You may decline or stop any part of the examination at any time.

Examination procedures are generally low risk. Known risks include temporary soreness or discomfort during or following certain tests. If diagnostic imaging is recommended, the purpose, procedure, and radiation exposure will be discussed separately and your consent obtained before any imaging is performed.

You may decline the examination or specific components of it. Alternatives include assessment by another regulated health professional or diagnostic imaging through your family physician. If the examination cannot be completed, Dr. Jelic may not be in a position to initiate a treatment plan at this visit, and declining care may allow your condition to persist, progress, or worsen. You have the right to ask questions before and during the examination and may withdraw your consent to any part of it at any time without negative consequence.

CONSENT TO TREAT

Chiropractic care addresses disorders of the musculoskeletal and nervous systems. It does not treat disease, and the College of Chiropractors of Ontario does not permit chiropractors to guarantee results or a cure for any condition. Your care will be provided by Dr. Dejan Jelic, D.C. If another regulated health professional is involved in your care at any time, you will be informed of their name and qualifications before they provide any service, and your consent will be obtained.

Following your examination and report of findings, Dr. Jelic will recommend a plan of care tailored to your condition. Procedures may include chiropractic spinal and extremity adjustments, soft tissue therapy, therapeutic modalities, rehabilitative exercises, and diagnostic imaging where clinically indicated. The nature, purpose, and method of each procedure will be explained before it is performed. If any procedure requires contact near a sensitive area of the body, you will receive an explanation and explicit consent will be obtained before proceeding.

Chiropractic care may offer benefits including pain reduction, improved range of motion, improved function, and enhanced quality of life. Individual results vary and no specific outcome is guaranteed.

As with all healthcare, chiropractic care carries some risk. Common side effects include temporary muscle soreness or stiffness, typically resolving within 24–48 hours. Less common risks include disc injury, rib fracture, or aggravation of a pre-existing condition. A rare but serious risk is VBA stroke following cervical spine manipulation. Current peer-reviewed research indicates that the association between cervical chiropractic care and VBA stroke is comparable in magnitude to the association between VBA stroke and a visit to a medical doctor, with no evidence of excess risk attributable to chiropractic care.¹ You are encouraged to raise any questions or concerns with Dr. Jelic before proceeding.

Alternatives to chiropractic care may include medical management, physiotherapy, massage therapy, acupuncture, prescribed exercise, watchful waiting, or no treatment. The likely consequences specific to your condition if you choose not to receive care will be discussed with you by Dr. Jelic.

You have the right to ask questions at any time before or during your care. You may withdraw your consent to any examination, procedure, or plan of care at any time and for any reason, without negative consequence to your access to care at this clinic. Any withdrawal will be documented in your health record.

This consent form provides your initial written consent for chiropractic care for your current condition. Consent is an ongoing process. New written consent will be obtained if a new condition is being treated, a materially different treatment is recommended, or there is a significant change in the risks relevant to your care.

Your personal health information is collected, used, and protected in accordance with the Personal Health Information Protection Act (PHIPA), 2004. You have the right to access your records and to ask questions about how your information is used.

PRINT PATIENT NAME

SIGNATURE

DATE

GUARDIAN, IF UNDER 18

WITNESS

DATE