DR. JAMES F. GILLIARD, *B.Kin. (Hons.), D.C.*
Doctor of Chiropractic — Certified in Acupuncture
4631 Palladium Way, Unit 6 Burlington, ON L7M 0W9
Tel (905) 634 - 6000 Fax (289) 337 - 1159

Name: ______________________ Gender (M/F/X) _______ Date of Birth _______/______/______
yyyy mm dd

Address: ___________________________ City: _________________ Postal Code: _________________

Home Phone: (_____) ______ - _______________ Work Phone: (_____) ______ - ______________

Cell Phone: (_____) ______ - _______________ Preferred Contact: □Home | □Work | □Cell

Email: ____ Referred By: ____________________________

Occupation: ______________________________ Is this a workplace injury (circle please)? Y N

Medical Doctor: __________________________________ Phone: (_____) ______ - ______________

Medical Doctor's Address: ____

Personal Health Information & Privacy

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

Personal information is information about an identifiable individual, such as name, contact information, gender, and age. Only necessary information is collected about you. Your patient file includes your health history, health measurements, examination, assessments, and their results; prognoses and other opinions formed; health services provided to and received by you; compliance with treatment, reasons for discharge, and other pertinent information. We also maintain records for payment and billing purposes. Collection of this information allows us to deliver safe and effective patient care, contact you, communicate with other health care professionals, complete and submit claims on your behalf to third party payors, comply with legal and regulatory requirements under the *Chiropractic Act* and the *Regulated Health Professionals Act*, process payments and collect unpaid accounts, and conduct research. We only share your information with your consent; the use, retention, and destruction of your personal information complies with the existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation, standards of our regulatory body *(College of Chiropractors of Ontario)*, and the law.

Staff members at Endorphins Health and Wellness Centre are aware of the sensitive nature of the information you have disclosed to us, and are trained in the appropriate uses and protection of your information; this included Dr. James Gilliard, office administration staff, clinical staff, and, when necessary, other authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

By signing this consent, I agree that I have reviewed the above information and given my informed consent for the collection, use, and/or disclosure of my personal information for the purposes that are listed, including contacting my medical doctor about my health care.

______________________	______________________	______________
Name (please print)	**Signature of Patient (or legal guardian)**	**Date (yyyy/mm/dd)**
______________________	______________________	______________
Witness to Patient Signature	**Signature of Witness**	**Date (yyyy/mm/dd)**

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PLEASE SHOW AREA(S) OF PAIN OR DISCOMFORT

- **Using the appropriate symbols, please describe where you feel the marked sensations.**
- **Mark all areas of discomfort or radiation.**
- **Include all affected areas.**

NUMBNESS	*PINS & NEEDLES*	*BURNING*	*ACHING*	*STABBING*
- - - - - - - - - - -	o o o o o o o o o o o o	X X X X X X	△ △ △ △ △	//////////
- - - - - - - - - - -	o o o o o o o o o o o o	X X X X X X	△ △ △ △ △	//////////
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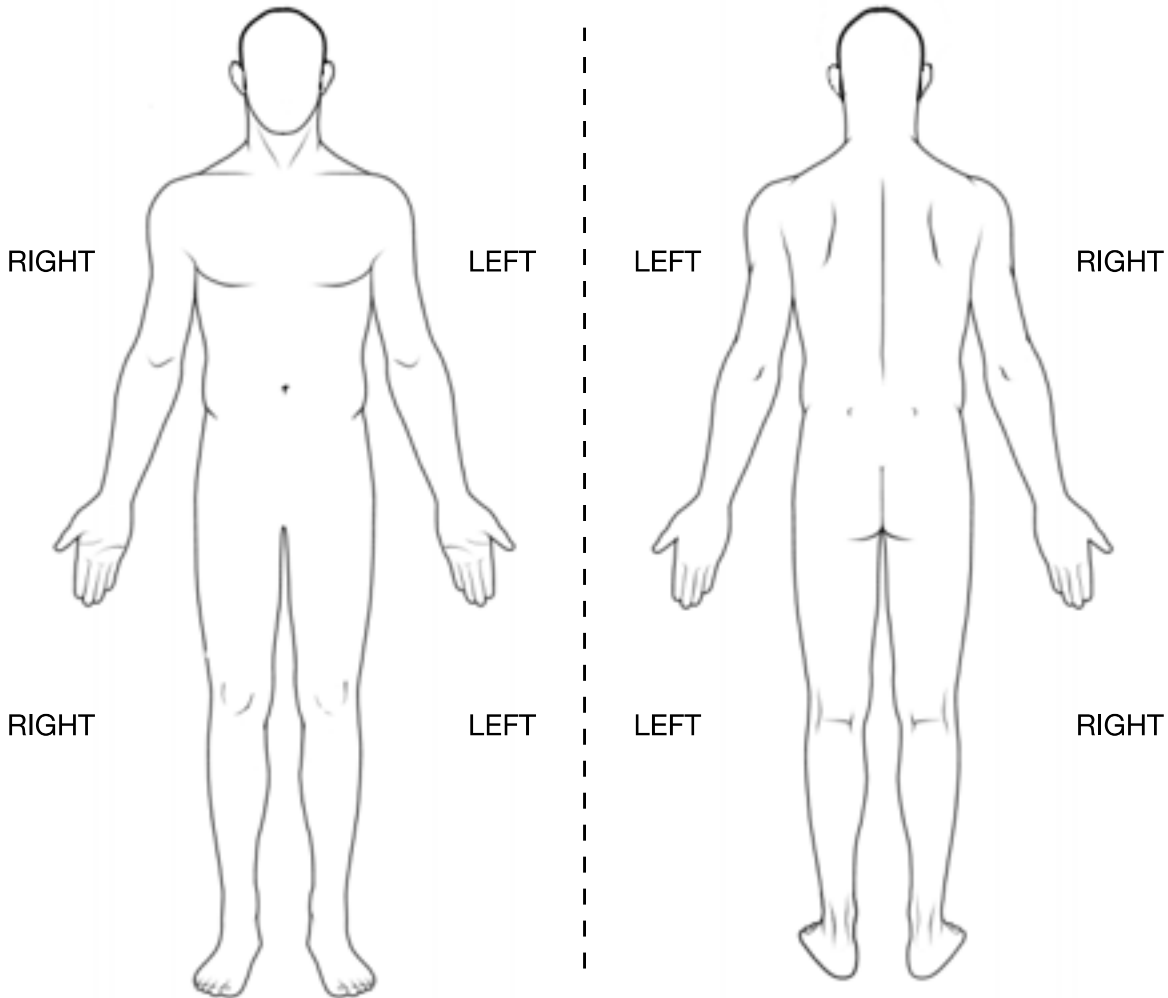

Name (please print) **Signature of Patient (or legal guardian)** **Date (yyyy/mm/dd)**

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Please mark "✓" in the box beside any CURRENT issues
Please mark "✗" in the box beside any PAST issues.

- ☐ Allergies
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Blood in urine
- ☐ Blurred or double vision
- ☐ Bowel/bladder issues
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Circulatory problems
- ☐ Clumsiness
- ☐ Concussions
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Difficulty Breathing
- ☐ Dizziness
- ☐ Double vision
- ☐ Eating disorder
- ☐ Excess hunger or thirst
- ☐ Fainting
- ☐ Fever
- ☐ Fractures
- ☐ Gall Bladder problems
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart attack/Angina
- ☐ Hemorrhoids
- ☐ Hepatitis A/B/C
- ☐ High blood pressure
- ☐ HIV/AIDS

- ☐ Hot flashes
- ☐ Jaundice
- ☐ Kidney issues
- ☐ Loss of consciousness
- ☐ Loss of sleep
- ☐ Loss of strength
- ☐ Low bone density
- ☐ Menstrual issues
- ☐ Nausea
- ☐ Nervousness
- ☐ Night pain
- ☐ Night sweats
- ☐ Numbness or tingling
- ☐ Problems speaking
- ☐ Problems swallowing
- ☐ Prostate problems
- ☐ Psychological disorder
- ☐ Rashes/itching
- ☐ Ringing in the ears
- ☐ Seizures
- ☐ Skin dryness
- ☐ Spitting blood/phlegm
- ☐ Stroke
- ☐ Swelling of ankles/joints
- ☐ Thyroid issues
- ☐ Tremors
- ☐ Ulcers
- ☐ Varicose veins
- ☐ Vision problems
- ☐ Weak immune system
- ☐ Weight loss/gain

- **Have you ever had any fractures or surgeries?**
  Yes No
  Where: ____________________

- **Have you ever been in a motor vehicle accident?**
  Yes No
  Most recent: ________________

- **Have you ever been hospitalized?**
  Yes No
  Reason: ___________________

- **Are you a current smoker?**
  Yes No
  Approx #/day: ______________
  Approx # of years: ___________

- **Are you a past smoker?**
  Yes No
  Approx #/day: ______________
  Approx # of years: ___________

- **Please list current medication or supplements:**
  (Name and Dosage)
  1. ________________________
  2. ________________________
  3. ________________________
  4. ________________________
  5. ________________________

Please check if you or anyone in your family have any of the following:

☐ Cancer	___ Myself	___ Mother	___ Father	___ Sibling	___ Other(specify):________
☐ Heart Disease	___ Myself	___ Mother	___ Father	___ Sibling	___ Other(specify):________
☐ Stroke	___ Myself	___ Mother	___ Father	___ Sibling	___ Other(specify):________
☐ Diabetes	___ Myself	___ Mother	___ Father	___ Sibling	___ Other(specify):________
☐ High Cholesterol	___ Myself	___ Mother	___ Father	___ Sibling	___ Other(specify):________
☐ Hypertension	___ Myself	___ Mother	___ Father	___ Sibling	___ Other(specify):________
☐ Other:	___ Myself	___ Mother	___ Father	___ Sibling	___ Other(specify):________

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Cost of Treatment

Chiropractic and/or Acupuncture and/or Laser Services

Consultation/Examination:	$ 108.00 (includes first treatment)
Subsequent Visits:	$ 52.00

OHIP no longer covers a portion of the costs of each Chiropractic visit (as of December 1, 2004).

Extended Health Benefits

Many extended health benefit plans will cover some or all of your Chiropractic fees, often to a yearly maximum. Please check with your plan provider to verify your coverage. Direct billing is available for some health benefit providers — please consult our office administration staff to see if you are eligible. Each extended benefit provider is unique, therefore we are unable to guarantee direct billing will be available for your plan. If direct billing is unavailable, the patient is responsible for payment on the day the service is rendered, and must then submit the receipt to their insurance company for reimbursement. All portions of treatment costs that are uncovered by extended benefits are the responsibility of the patient.

Motor Vehicle Accident Coverage

If you have been involved in a motor vehicle accident, your automobile insurance will cover the cost of medical rehabilitation, which also includes care by a Chiropractor. The auto insurance company will pay for any costs not covered by an extended health benefits plan. This means that if you have coverage from your employer, or other extended health benefits, all claims must first go through your extended benefit plan, and your automobile insurance carrier will cover any uncovered amount (within claim guidelines established by the province).

WSIB Claims

If your injury has occurred while you were at work, the full cost of Chiropractic care is covered for approved claims. The injury must be reported to the employer as soon as possible. If the Workplace Safety and Insurance Board (WSIB) deny the claim, all uninsured costs are the responsibility of the patient.

Billing as "Acupuncture"

Some extended health benefit providers offer billing options as "Acupuncture" treatments. Although you can receive acupuncture as part of your treatments (per the College of Chiropractors of Ontario), since 2013 the practice of billing treatments as "Acupuncture" services in Ontario is restricted to members of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario. We are therefore unable to bill directly as "Acupuncture" services with Dr. Gilliard.

By signing this consent, I acknowledge that I have read the above explanation of fees and accept the terms to which they apply to my treatment at Endorphins Health and Wellness Centre.

Name (please print)	**Signature of Patient (or legal guardian)**	**Date (yyyy/mm/dd)**

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