

**TRIGENICS®
MYONEURAL
TREATMENT CENTRE**

343 Eglinton Avenue East
Toronto, ON M4P 1L7
Tel: 416-481-1936
www.trigenicsinstitute.com

Please print the following information. It is important for our records and your health.

NAME OF PATIENT: _____ **BIRTH DATE:** _____

DAY/MONTH/YEAR

ADDRESS: _____ **CITY:** _____ **POSTAL CODE:** _____

HOME PHONE: _____ **BUSINESS PHONE:** _____ **CELL PHONE:** _____

E-MAIL ADDRESS: _____

EMPLOYED BY: _____ **ADDRESS:** _____

OCCUPATION: _____

CIRCLE: MARITAL STATUS: S M W D **CHILDREN? Y N** **AGES OF CHILDREN:** _____

EXTENDED HEALTH: **COMPANY NAME** _____ **POLICY #** _____

REFERRED TO OUR OFFICE BY: _____

NAME & ADDRESS OF CHIROPRACTIC PHYSICIAN? _____

NAME OF MEDICAL DOCTOR: _____ **TEL #** _____

DOCTORS ADDRESS _____ **E-MAIL ADDRESS** _____

WHAT IS YOUR PROBLEM: _____

HOW LONG HAVE YOU HAD IT? _____ **HAVE YOU LOST WORK TIME?** _____

IS IT GETTING WORSE? _____ **REMAINS THE SAME?** _____

DOES IT INTERFERE WITH YOUR SLEEP? _____ **WORK?** _____ **DAILY ROUTINE?** _____

HAVE YOU HAD THIS PROBLEM BEFORE/SIMILAR PROBLEM? _____ **WHEN?** _____

WAS IT A RESULT OF AN ACCIDENT? _____ **AUTO?** _____ **ON THE JOB?** _____ **OTHER:** _____

IF SO, DESCRIBE THE CIRCUMSTANCES _____

PLEASE LIST THE DOCTORS YOU HAVE SEEN FOR THIS PROBLEM _____

PRIOR SURGERY? _____ **WHEN?** _____

MEDICATIONS TAKEN AT PRESENT

FOR WOMEN ONLY: DATE OF LAST PERIOD: _____ **ARE YOU PREGNANT?** _____

PLEASE LIST AND DESCRIBE ALL PAST ACCIDENTS, FALLS, INJURIES, ETC. YOU HAVE HAD. PLEASE GO BACK AS FAR AS CAN REMEMBER. IF THERE ARE MORE THAN 3 PLEASE USE THE BACK OF THIS PAPER.

TRAUMA (1) _____

TRAUMA (2) _____

TRAUMA (3) _____

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT? _____

NAME & PHONE # OF RELATIVE FOR EMERGENCY _____

Signature: _____ **Date:** _____



PATIENT'S NAME: _____

(Please Print)

Patient's Age: _____ **Sex:** _____

Patient's Signature **Date**

Instructions: Please circle the correct response. Sign and date when completed.

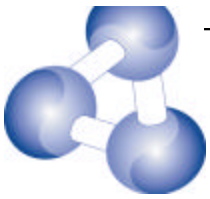
Have you ever been diagnosed or told you had any of the following?

DOCTOR'S NOTES

- | | | |
|---|---------------------------|--------------------------|
| 1. High Blood Pressure (hypertension) | <input type="radio"/> Yes | <input type="radio"/> No |
| 2. Hardening of the arteries (arteriosclerosis) | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Diabetes | <input type="radio"/> Yes | <input type="radio"/> No |
| 4. Heart or blood vessel diseases | <input type="radio"/> Yes | <input type="radio"/> No |
| 5. Bone spurs on the neck bone (cervical spondylosis) | <input type="radio"/> Yes | <input type="radio"/> No |
| 6. Whiplash injury (flexion-extension injury)(cervical sprain) | <input type="radio"/> Yes | <input type="radio"/> No |
| 7. Have any of your relatives ever suffered a stroke? | <input type="radio"/> Yes | <input type="radio"/> No |
| 8. Were you ever a smoker? From _____ To _____ | <input type="radio"/> Yes | <input type="radio"/> No |
| 9. Do you take any medication on a regular basis?
What? (Cumidine, Heparin, Aspirin, Anti-hypertensive medicine, etc)
_____ | | |
| 10. (Women Only) Have you ever taken oral contraceptives?
From _____ To _____ | <input type="radio"/> Yes | <input type="radio"/> No |

Have you ever experienced any of the following, even short temporary attacks?

- | | | |
|---|---------------------------|--------------------------|
| 1. Blurred Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| 2. Double Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Diminished or partial loss of vision in one or both eyes | <input type="radio"/> Yes | <input type="radio"/> No |
| 4. Complete loss of vision in one or both eyes | <input type="radio"/> Yes | <input type="radio"/> No |
| 5. Ringing, buzzing or any noise in ear(s) | <input type="radio"/> Yes | <input type="radio"/> No |
| 6. Hearing loss in one or both ears | <input type="radio"/> Yes | <input type="radio"/> No |
| 7. Slurred speech or other speech problems | <input type="radio"/> Yes | <input type="radio"/> No |
| 8. Difficulty swallowing | <input type="radio"/> Yes | <input type="radio"/> No |
| 9. Dizziness | <input type="radio"/> Yes | <input type="radio"/> No |
| 10. Temporary lack of understanding | <input type="radio"/> Yes | <input type="radio"/> No |
| 11. Loss of consciousness, even momentary blackouts | <input type="radio"/> Yes | <input type="radio"/> No |
| 12. Numbness or loss of sensation in the face, fingers, hand,
arms, legs or other parts of your body | <input type="radio"/> Yes | <input type="radio"/> No |
| 13. Any other abnormal sensations in any part of your body | <input type="radio"/> Yes | <input type="radio"/> No |
| 14. Weakness, clumsiness or loss of strength in the face,
fingers, hand, arms or legs | <input type="radio"/> Yes | <input type="radio"/> No |
| 15. Sudden collapse without loss of consciousness | <input type="radio"/> Yes | <input type="radio"/> No |



TRIGENICS®
MYONEURAL
TREATMENT CENTRE

Name: _____ Signature: _____ Date: _____

problem to you in the past.

<p>GENERAL SYMPTOMS</p> <p>Headache Fever Chills Sweats Fainting Dizziness Convulsions Loss of Sleep Fatigue Nervousness Loss Of Weight Allergy Wheezing Neuralgia</p> <p>SKIN</p> <p>Skin Eruptions Itching Bruises Easily Dryness Boils Varicose Veins Sensitive Skin Hives or Allergy</p> <p>RESPIRATORY</p> <p>Chronic Cough Spitting up Phlegm Spitting up Blood Chest Pain Difficulty Breathing</p>	<p>E.E.N.T.</p> <p>Failing Vision Near Sightedness Far Sightedness Crossed Eyes Eye Pain Deafness Earache Ear Discharge Nose Bleeds Nasal Obstruction Sore Throat Hoarseness Hay Fever Asthma Dental Decay Gum Trouble Frequent Colds Enlarged Thyroids Tonsillitis Sinus Infection Nasal Drainage Enlarged Glands</p> <p>GENTOURINARY</p> <p>Frequent Urination Painful Urination Blood in Urine Kidney Infection Kidney Stones Bed Wetting Inability to Control Urine Prostate Trouble</p>	<p>CARDIO VASCULAR</p> <p>Rapid Beating Heart Slow Beating Heart High Blood Pressure Low Blood Pressure Pain over Heart Previous Heart Stoke Hardening of Arteries Swelling of Ankles Poor Circulation Paralytic Stroke</p> <p>MUSCLE & JOINT</p> <p>Stiff Neck Back Ache Swollen Joints Painful Tail Bone Foot Trouble Pain in Shoulders Hernia Spinal Curvature Faulty Posture Arthritis Numbness or pain in arms, hands Numbness or pain in legs, feet Knee Pain or Swelling Hip Pain Flat Feet Wrist Pain or Stiffness</p>	<p>GASTROINTESTINAL</p> <p>Poor Appetite Difficult Digestion Excessive Hunger Belching or Gas Nausea Vomiting of Blood Pain over Stomach Constipation Colon Trouble Hemorrhoids (piles) Intestinal Worms Liver Trouble Gall Bladder Trouble Jaundice Colitis</p> <p>FOR WOMEN ONLY</p> <p>Painful Menstruation Excessive Flow Hot Flashes Irregular Cycle Cramps or Backache Previous Miscarriage Vaginal Discharge Congested Breast Lumps in Breast Menopausal Symptoms</p>
--	--	--	--

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES

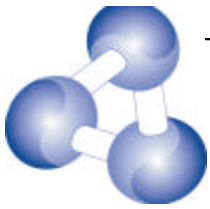
Appendicitis	Malaria	Chicken Pox	Alcoholism	Anorexia
Scarlet Fever	Tuberculosis	Diabetes	Venereal Infection	HIV / AIDS
Diphtheria	Whooping Cough	Cancer	Epilepsy	
Typhoid Fever	Anemia	Heart Disease	Mental Disorder	
Pneumonia	Measles	Goiter	Eczema	
Rheumatic Fever	Mumps	Influenza	Hepatitis A, B or C	
Polio	Small Pox	Pleurisy	Bulimia	

Were you ever knocked unconscious? YES, NO

Accidents of Fall: Fractures or Dislocations (Please describe fully) _____

Please check if this is an Industrial Accident Case: YES, NO

Any Other Accidents: _____

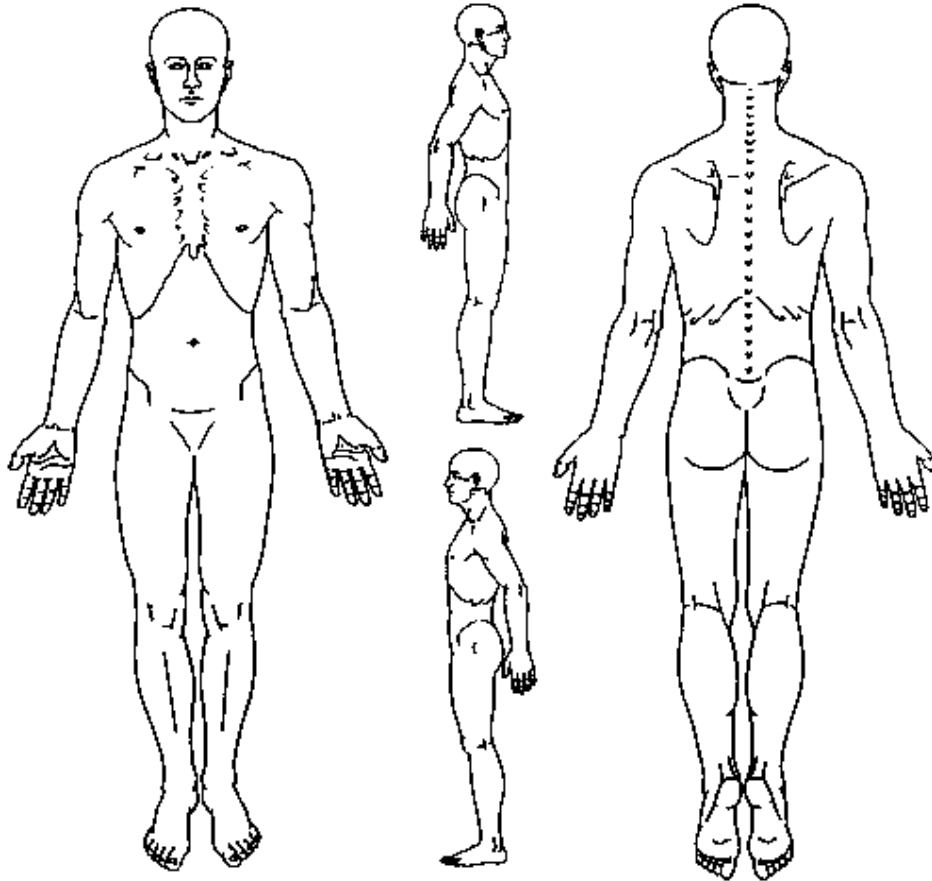


Name: _____ Signature: _____

Date: _____

GRAPHICAL DESCRIPTION OF PAIN TYPE AND LOCATIONS:

Please draw in the diagram where you are experiencing your pain using the letters in the legend below. If you have pain that refers (starts one place then moves) draw arrows or use letters to indicate this.



A = Ache	P = Pins & Needles	B = Burning	S = Stabbing	N = Numbness	W = Weakness
----------	--------------------	-------------	--------------	--------------	--------------

For each complaint, please denote a number 0-10 for the intensity of pain

(i.e. 0 = no pain, 10 = take me to the emergency room! pain)

Please circle for General Level of Pain: 1 2 3 4 5 6 7 8 9 10

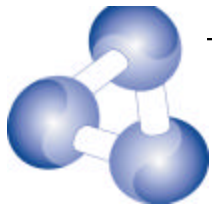
1. When did the pain begin?

2. Is it constant or intermittent? If intermittent, how often do you get it?
Do you notice it more at certain times of the day?

3. Have you noticed if anything aggravates it (makes it worse)? Does anything bring you relief (feel better)?

4. Do you have any family history of illness on either your mother or father's side? (eg. Arthritis, heart disease, diabetes, cancer, etc.)

5. Have you suffered any previous trauma or had any surgeries previously?



**TRIGENICS®
MYONEURAL
TREATMENT CENTRE**

343 Eglinton Avenue East
Toronto, ON M4P 1L7
Tel: 416-481-1936
www.trigenicsinstitute.com
clinic@trigenicsinstitute.com

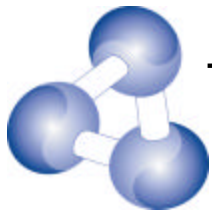
Please fill in this form in order for us to *maximize your extended healthcare* and *minimize your out-of-pocket expenses*

EXTENDED HEALTH COVERAGE

Patient Name	
Insurance Company	
Policy No:	
ID No.:	
Maximum Coverage Per Year Per Insured for:	
Chiropractic	
Osteopathic Medicine	
Massage	
Acupuncture	
Naturopathy	
Physiotherapy	
Orthotics (indicate # of pairs)	/ year / 2 years
Medical Doctor's referral required for Orthotic prescription? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your Extended Healthcare Insurance cover your family? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Maximum Coverage Per Family for:	
Chiropractic	Per family member
Osteopathic Medicine	
Massage	
Acupuncture	
Naturopathy	
Physiotherapy	
Orthotics (indicate # of pairs)	/ year / 2 years
Calendar Year End (usually December 31st):	
Does your Extended Healthcare Coverage begin after OHIP expires? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Your Chiropractic care is not fully funded by OHIP. Please contact your insurance company and check your policy or speak with your Human Resources Department prior to your next appointment at our office.

Please return your completed form to our office.
Thank you.



TRIGENICS®

TREATMENT CENTRE

Patient Informed Consent Statement

for Consultation and/or Examination and/or Treatment

I hereby request and consent to a consultation as well as a physical examination and ensuing treatment relating to my condition and circumstances in the performance of diagnostic assessment procedures, chiropractic adjustments and other chiropractic manipulative and therapeutic procedures, including Trigenics® and other various modes of manual medicine, physical and exercise therapy and, if necessary, requisition of diagnostic radiographs (X-rays), MRIs or ultrasound on me by any of the doctors of the Trigenics Treatment Centre.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic doctors or personnel, the nature and purpose of chiropractic treatment and other related manual medicine or therapeutic procedures deemed necessary for my care. I understand that results are not guaranteed and that any fees paid by me, as per the Trigenics Treatment Centre Fee Schedule, will be strictly for products supplied or services rendered and not based on results. I further understand that, in certain cases, treatment may cause a worsening of my symptoms or condition which is usually, but not always, temporary.

I further understand and am informed that, as in all health care or medical procedures, in the practice of chiropractic, there are some risks to treatment including, but not limited to, residual or intractable pain in the area being treated or other associated areas, muscle spasm, bruising, sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure, which the doctor(s) feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent as well as the fee schedule. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-mentioned chiropractic and related manual medicine procedures. This consent form will cover my entire course of treatment.

TO BE COMPLETED BY PATIENT:

PRINT PATIENT'S NAME

*SIGNATURE OF PATIENT
(OR PARENT/GUARDIAN)*

WITNESS

DATE SIGNED

DATE

INITIAL EXAMINING DOCTOR



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment **FORM – L**

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____
(please print)

Name: _____
(please print)