Universal Health & Rehabilitation, PC

28 Finch Avenue West, Suite 212
Toronto, Ontario M2N 2G7
Pain.Drs@gmail.com

Tel: (416) 628-1336

"Your Multidisciplinary Healthcare Solution"

Thank you for choosing our office!

To ensure your visit with us is a pleasant one, here are the procedures you can expect upon arrival.

Paperwork: You will have to complete a history (personal/medical) and pain form prior to assessment. This will help us to help us to get to know you. The doctor will use this information to help formulate recommendations for your care. This can be done by downloading and completing the forms prior to your visit, or while at the office.

Consultation: You will meet the Dr. Mazzarella or Dr. Marek. Dr. Mazzarella or Dr. Marek will review your health history and determine if yours is a chiropractic case. You will be informed of any of the fees for office procedures before they are performed. Dr. Mazzarella and Dr. Marek will answer all of your questions, and request special testing if needed.

Examination: Our examination can consist of Physical Examination, Soft Tissue Examination, Neurological Examination, Orthopedic Examination, Posture Analysis, Digital Vestibular Testing, Gait Analysis and Spinal Analysis.

Treatment Plan and Report of Findings: After a complete evaluation, our doctors will provide a report of findings, indicating what if any conditions or injuries you have that could be limiting your health, causing pain or reducing your ability to live a full and healthy life. Our doctors use state of the art imaging and computerized models so that you understand your condition and what is needed to get you better/healthy/recovered as soon as possible.

Scheduling and Cancellation: Universal Health & Rehabilitation requires 24-hour cancellation notice. We allow this via phone, text or email. Failure to provide 24-hour notice can result in a cancellation fee of $35.00.

Universal Health & Rehabilitation Fee's (Subject to change)

Please see our website.

Universal Health & Rehabilitation also offers a free 15-minute consultation for everyone.

_____	_____	_____
Patient Name	Patient Signature	Date

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New Patient Intake Form: **Date:**

Name _____ **Date of Birth** _____ **Age** _____

Address _____ **Apt:** _____**City** _____

Province _____ **Postal Code** _____

Email _____ **Telephone Home** _____

Emergency Contact _____ **Telephone** _____

Please check the Box the best applies

( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widow **Marital Status**

( ) Male ( ) Female **Gender**

( ) Car Accident ( ) Work Accident ( ) Pain ( ) Wellness **What Brings you in today?**

Previous Treatment Experience

Have you been treated by another doctor for this condition? ( ) **Yes** ( ) **No**
If yes, by who:

_____ _____ _____
Doctors Name **Clinic Name** **Phone**

Did this treatment help?_____

Have you seen a Chiropractor before? ( ) **Yes** ( ) **No**
If yes, How was your experience? ( ) **Great** ( ) **Good** ( ) **Ok** ( ) **Bad**

Family Doctor

Who is your Family Doctor? _____ **Tel:** _____

Address: _____
Would you like us to provide your MD with information regarding your health? ( ) **Yes** ( ) **No**

Who can we Thank for the Referral

Name: _____ **Tel:** _____ **Other:** _____

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Work Information:

Date:

Employer Name _____

Primary Tasks _____

Are you currently working? _____

Do you have Extended Health

( ) **Yes** ( ) **No**

If you have Extended Health and Would like us to Bill Directly, we can do so for the following Companies:

Company Name: _____ **Provider Number:** _____

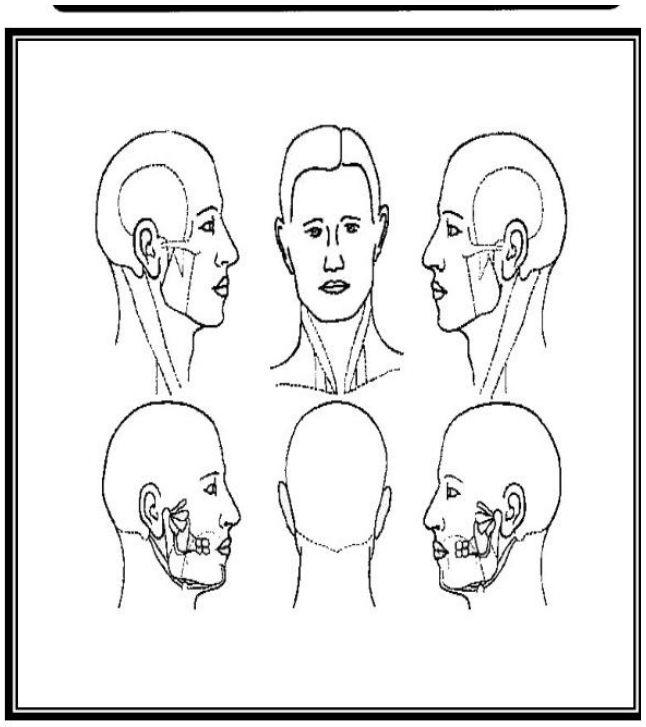
Group Number: _____

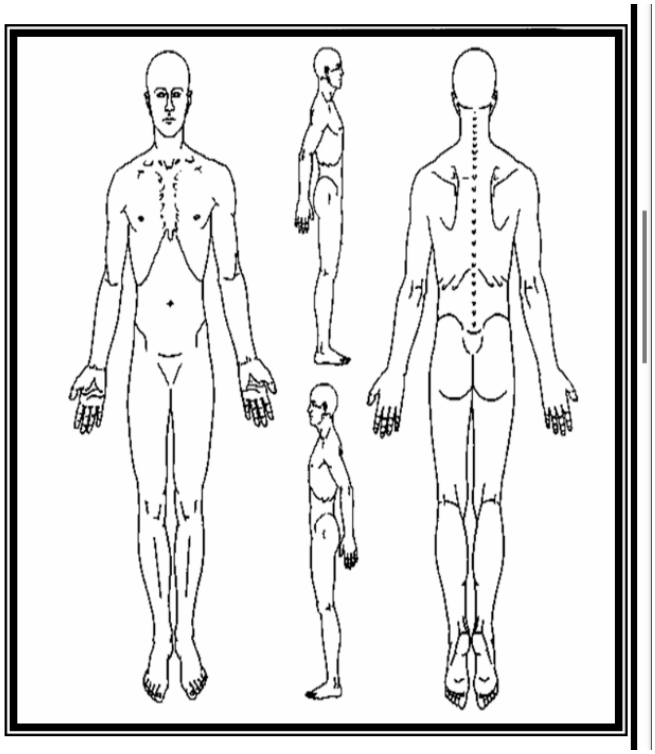
Please initial if you provide consent for Direct Billing ( )

Please Circle all that apply

What Makes you feel Better?	**Ice**	**Heat**	**Exercise**	**Medication**	**Rest**	**Other**
What Makes you feel Worse?	**Sitting**	**Standing**	**Lifting**	**Carrying**	**Pushing**	**Pulling**
	Turning	**Working**	**Activity**	**Other**		

Please Place an X where you have Pain Today





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What Services are you Interested in receiving or learning about today? Please circle all that apply.

Chiropractic	**Acupuncture**	**Physiotherapy**
Massage Therapy	**Vestibular Rehabilitation**	**Concussion Therapy**
Pain Management	**Wellness**	**Nutrition**
Exercise Prescription	**Orthotics / Postural Improvements**	

Past Medical - Please Check all that apply

Patient Current Complaints **Check (✓) if you have any of the following:**

- ☐ Dizziness
- ☐ Headaches
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Chest Pain
- ☐ Rib Pain
- ☐ Shoulder Pain
- ☐ Arm/Forearm Pain
- ☐ _____
- ☐ Elbow Pain
- ☐ Wrist/Hand Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Thigh/Leg Pain
- ☐ Ankle/Foot Pain
- ☐ Pins & Needles in Arms
- ☐ Pins & Needles in Legs
- ☐ Numbness
- ☐ Blurred Vision
- ☐ Fatigue
- ☐ Fever/Infection
- ☐
- ☐ Ringing/Pain in Ears
- ☐ Abdominal Pain
- ☐ Urinary/Bowel Incontinence/Difficulty
- ☐ Nausea/Vomiting
- ☐ Loss of Sleep
- ☐ Constant Irritability
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Jaw Pain
- ☐ Depression
- Other: ☐ _____
- ☐

Are you pregnant? ☐ Yes, Due Date: _____ ☐ No

Past Medical History **Check (✓) if you have any of the following:**

- ☐ Anemia
- ☐ Hives or Eczema
- ☐ Chicken Pox/Shingles
- ☐ Glaucoma/Cataracts
- ☐ Pneumonia
- ☐ Hernia/Ulcer
- ☐ Asthma
- ☐ Cancer
- ☐ Venereal Disease
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Pacemaker
- ☐ Any Birth Defects (please list):
- ☐
- ☐
- ☐ _____

- ☐ Tuberculosis
- ☐ AIDS/HIV+
- ☐ High/Low Blood Pressure
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Disc Herniation/Bulge
- ☐ Epilepsy
- ☐ Blood/Plasma Transfusion
- ☐ Headaches
- ☐ Breast Lump
- ☐ Diabetes I/II
- ☐ Brain Disease
- ☐ Infection Mono
- ☐
- ☐

- ☐ Thyroid Disease
- ☐ Bleeding Tendency
- ☐ Hepatitis _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ History of Tobacco Use
- ☐ History of Alcohol Use
- ☐ History of Drug Abuse
- ☐ Recent Infection/Flu/Dental Work
- ☐
- ☐

Any Other Disease (please list): _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problem/ Stroke ☐ Neurological Disorder

Statement:

To the best of my knowledge. The questions on these forms have been accurately and honestly answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctors office of any changes in my medical status.

_____ _____

Name / Guardian Date

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CONSENT TO CHIROPRACTIC TREATMENT

Please Read Carefully

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- Temporary worsening of symptoms – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- Skin irritation or burn – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- Sprain or strain – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- Rib fracture – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- Injury or aggravation of a disc – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- Stroke – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives
Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.
Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR. CCPA 09.14 Page 2 of 2
Retrieved from Canadian Chiropractic Protective Agency.

CONSENT TO ACUPUNCTURE TREATMENT – FORM AC FROM THE CCPA

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above- named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

READ BEFORE SIGNING

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic and acupuncture treatment as proposed to me.

_____ Name (Please Print)

_____ Signature of patient (or legal guardian)

_____ Signature of Chiropractor Date: _____