Office Policy

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service, and to provide the best family health care available. In return, we expect you to experience improved health. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

Appointment Scheduling

In order for Dr. Chudolinski or Dr. Manga to provide the best quality care we ask that you arrive promptly for your scheduled appointment. If you are late for your appointment and another patient who is scheduled after you arrives on time, they will be treated before you, and we will do our best to fit you in for your treatment as soon as possible. Please note that you will only be given the time that you are scheduled for, so if you are late by 5 minutes and have a 15 minute time slot booked your treatment that day will only be 10 minutes in duration.

All treatments are generally scheduled in a 15 minute interval. During this time Dr. Chudolinski or Dr. Manga will be able to treat up to two areas of complaint. In fairness to other patients, and in order for Dr. Chudolinski or Dr. Manga to keep on schedule please schedule an additional 15 minute interval (30 minutes total treatment time) if you have more than two areas of complaint, or you have a new injury or complaint that you would like Dr. Chudolinski or Dr. Manga to assess.

Missed or Changed Appointmients

Dr. Chudolinski or Dr. Manga has designed a specific course of treatment to allow proper care, a must for spinal and postural correction to remove nerve interference. We will work with you to construct a calendar of dates and times to save you time on each visit. If an appointment must be changed, we would appreciate 24 hours notice, or as soon as you know you will not be able to make it, so that someone else may be scheduled in your time. To maintain the pace of correction, all missed appointments should be rescheduled later on the same day or within 24 hours. Please let our front desk know and changes will be made accordingly. Should you miss an appointment without prior notification to our office, you will be charged the FULL FEE for the type of appointment you had scheduled.

MVA / WSIB

If you have been involved in a motor vehicle accident or a work accident for your current complaint please inform us immediately as there may be additional documentation that needs to be filled in. Please note that if your claim is not approved you will be responsible for paying all service fees.

Financial Agreements

If for any reason, you cannot keep your financial agreement, please inform us immediately to prevent any misunderstanding. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

Remember

Spinal correction and healing takes time. If you do not feel satisfied with your body's responses, please discuss this with Dr. Chudolinski or Dr. Manga. We want you to obtain the most from your chiropractic care.

OFFICE USE ONLY Patient Name: ____________________________ File No.: _______________

PRIVACY/CONFIDENTIALITY

All documentation in your file will be kept confidential and only shared with OHIP, WSIB or other insurance companies, and office staff as may be required. Please be aware that although you may have other family members or friends who are patients at this office, we can not disclose any information regarding their care or billings without consent from that patient, in order to maintain doctor-patient confidentiality. For further details on patient privacy and confidentiality, see the posted information in Dr. Chudolinski's or Dr. Manga's treatment rooms.

REFERRALS

The successes of our office and the health of your loved ones greatly depend on your referrals. If there is someone you know that you would like to invite to our office, please let us know. Additionally, should you have someone in another town that you feel would benefit from an assessment by a chiropractor, we would be happy to provide you with names of doctors in their area. As an added benefit Dr. Chudolinski or Dr. Manga will be offering you a complimentary treatment for all patients that you refer to our office.

CHIROPRACTIC EXCELLENCE

Occasionally, Dr. Chudolinski will be attending advanced training courses to enhance his/her ability to provide you with the highest quality of care. We will be building your schedule around these times or have a locum doctor brought into the practice to continue care without interruption.

TELEPHONE

It is common practice in our office to call you at your home or place of work for the following reasons:

1. To remind you of your next appointment
2. To call if you have missed an appointment without prior notice
3. To call and reschedule an appointment that was missed
4. For Dr. Chudolinski to follow-up with you after your initial treatment
5. Long term follow up if you have not been in for treatment
6. Miscellaneous information regarding billings, treatment plans, etc.

We may leave a message for you at your home or work if you are not there. Please let us know by checking below if it is ok for our office to follow these practices with you. Note: we will only contact you at your place of work if we are unable to reach you at your home or on your cell phone.

☐ **Yes, ok to call and/or leave messages** ☐ **No, not ok to call and/or leave messages**

READ BEFORE SIGNING

I have read and understand the above policies and agree to abide by them.

______________________________ _______________
Patient Signature Date

______________________________ _______________
Witness Date

OFFICE USE ONLY	Patient Name: ______________________	File No.: __________

Information for the New Patient

FEE SCHEDULE

INITIAL VISIT

ADULT	$80.00
STUDENT/SENIOR/CHILD*	$60.00

REPORT OF FINDINGS (X-RAYS) $20.00

SUBSEQUENT VISITS

	ADULT	STUDENT*	SENIOR/CHILD*
CHIROPRACTIC ONLY (ONE 15 MINUTE TIME SLOT)**	$35.00	$30.00	$25.00
CHIROPRACTIC ONLY (ONE 30 MINUTE TIME SLOT)**	$60.00	$55.00	$50.00
ACUPUNCTURE ONLY	$35.00	$30.00	$25.00
CHIROPPRACTIC & ACUPUNCTURE (SAME VISIT, 30 MINUTES)	$60.00	$55.00	$50.00

* Student rates are available for those who are in University, senior rates apply to those who are over 65 years of age, and child rates are available for children who have at least one parent who is also a patient of Dr. Chudolinski or Dr. Manga.

** Time slots are allocated by the number of areas that are being treated or if modalities such as ultrasound or interferential current are used. One 15 minute time slot is booked for up to two areas of complaint (note: the entire spine is considered one area of complaint). Two 15 minute time slots are booked if a patient is having more than two areas of complaint treated.

Extended Health Care Coverage

Those who have extended or supplemental health insurance through your place of employment will often have coverage for chiropractic or acupuncture care. If you would like to claim your chiropractic or acupuncture care we will be happy to provide you with a statement of your account. All fees to be claimed for reimbursement must be done by the patient.

Auto Insurance Claims: Accepted and billed directly upon approval from the insurance company.

W.S.I.B. Claims: Accepted upon verification from W.S.I.B.

I have read the above information outlining the office fee schedule and have completed the attached confidential patient history form to the best of my ability and certify that the information is true and accurate.

READ BEFORE SIGNING

Date: ________________

____
Patient Signature

CONFIDENTIAL PATIENT HEALTH RECORD

Name: ______________________________ Birthdate: / / Gender: ☐ M ☐ F File No.: ________

Address: ______________________________ City/Province: ______________ Postal Code: __________

Home Phone: ________________ Business Phone: ________________ Email: ______________________

Employer: ______________________________ Type of Work: ______________________________

Marital Status: ____________________________________ Number of Children: ____________

Emergency Contact: __________________________________ Phone Number: _____________________

Who may we thank for referring you to this office? ____

CURRENT HEALTH CONDITION

Current Health Complaint(s): ____

When did this begin? ____

Has the condition occurred before? ☐ Y ☐ N When? ____________________________

Does your pain travel anywhere (e.g. into arms or legs)? ☐ Y ☐ N

Where? ____

What does it feel like:

☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning ☐ Other: _________

Frequency of Pain: ☐ Constant ☐ Intermittent; how often? ____________________

How long does each episode last? _________ When was your last episode? __________

What makes the condition feel worse?______________________________________

What makes the condition feel better?______________________________________

What activities are you unable to do because of this condition? __________________

Any previous injuries to the area of your complaint? ☐ Y ☐ N When? _______________

Have you seen another health professional for this condition? ☐ Y ☐ N

Who? ____________________ Treatment Received: ____________________________

Previous Chiropractic care? ☐ Y ☐ N Who? ______________________________

Condition treated: _______________ Treatment Received: _______________________

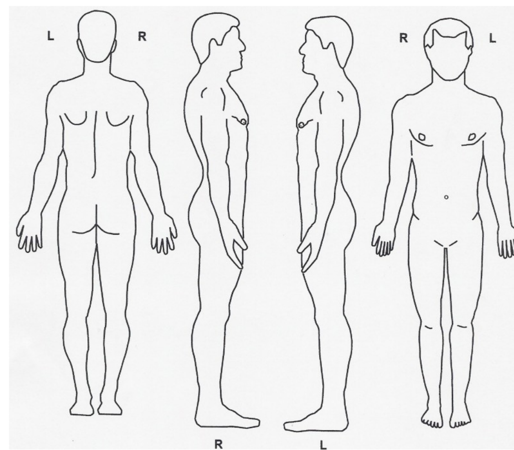
Doctor's Notes:

Head to Toe
Chiropractic and Wellness Centre

On the diagram to the left, please draw out your location of pain, with the following legend:

xxx - sharp /// - dull/ache zzz - burning

ooo - numb *** - pins and needles



Please circle a number below to indicate the severity of your pain:

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Has the condition been getting: ☐ Worse ☐ Better ☐ Stayed the Same

Dr. Artur Chudolinski, HBSc, DC
Dr. Jasmin Manga, HBSc, DC

OFFICE USE ONLY	Patient: ________________________	File No.: ___________

Below is a list of diseases and symptoms which may seem unrelated to the purpose of your appointment. However, it is important that you **check any that you have currently or circle any that you have had in the past** as these may affect the overall course of your chiropractic care.

Nervous System
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness/Confusion
- ☐ Depression
- ☐ Convulsions/Seizures/Fainting
- ☐ Cold / Tingling (hands/feet)
- ☐ Multiple Sclerosis
- ☐ Alzheimers
- ☐ Dementia
- ☐ Other: ____________________

Muscles/Joints
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Elbow Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Hip Pain
- ☐ Foot Pain
- ☐ Plantar Fasciitis
- ☐ Jaw Pain / Clicking
- ☐ Joint Pain / Stiffness
- ☐ Other: ____________________

Ears/Nose/Throat
- ☐ Double/Blurry Vision
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Sinus Congestion/Postnasal Drip
- ☐ Nasal Polyps
- ☐ Cataracts/Glaucoma
- ☐ Environmental Allergies
- ☐ Other: ____________________

Respiratory
- ☐ Lung Problems
- ☐ Pneumonia
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Other: ____________________

Heart
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure High / Low
- ☐ Irregular Heart Beat
- ☐ Varicose Veins
- ☐ Ankle Swelling / Edema
- ☐ Stroke
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Bypass Surgery
- ☐ Other: ____________________

Digestion
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas / Bloating After Meals
- ☐ Heartburn
- ☐ Ulcer
- ☐ Other: ____________________

Bowel/Bladder
- ☐ Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Black / Bloody Stool
- ☐ Discoloured Urine
- ☐ Painful Urination
- ☐ Painful Bowel Movement
- ☐ Frequent Urination
- ☐ Other: ____________________

General
- ☐ Fatigue
- ☐ Medicinal Allergies
- ☐ Loss of Sleep
- ☐ Headaches
- ☐ Cancer: ____________________

Male
- ☐ Prostate Problem
- ☐ Sexual Dysfunction
- ☐ Breast Pain/Lumps
- ☐ Other: ____________________

Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain
- ☐ Yeast Infections
- ☐ Breast Pain/Lumps
- ☐ Endometriosis
- ☐ Other: ____________________

When was your last period?
/ /

Are you pregnant? ☐ Y ☐ N
Due Date: / /

Diet
- ☐ Vegetarian
- ☐ Lactose Intolerant
- ☐ Glutein Intolerant
- ☐ Food Allergies
- ☐ Other: ____________________

Lifestyle Stress
- ☐ High
- ☐ Moderate
- ☐ Little

Family History
(INDICATE MOM/DAD/SISTER/BROTHER)
- ☐ Diabetes
- ☐ Cancer
- ☐ Arthritis
- ☐ Stroke
- ☐ Neurological Disorder
- ☐ Blood Pressure Problems
- ☐ Heart Problems
- ☐ Seizures/Convulsions
- ☐ Similar Condition to your current complaint
- ☐ Other: ____________________

Head to Toe
Chiropractic and Wellness Centre

OFFICE USE ONLY	Patient: ______________________	File No.: __________

Health History

Current Family Doctor: ____ Date of Last Physical Exam: / /

Have you had any of the following done in the last six months: ☐ X-ray ☐ Ultrasound ☐ MRI ☐ CT scan

Have you had any blood work done in the last year? ☐ Y ☐ N If yes, why? _______________________________

Current Weight: _________ Height: _________ Any recent weight: ☐ Loss ☐ Gain How much? __________

Check any of the following diseases you have had or currently have:

☐ Rheumatic Fever	☐ Measles	☐ Chicken Pox	☐ Cancer	☐ Epilepsy
☐ Polio	☐ Mumps	☐ Small Pox	☐ Thyroid	☐ Eczema
☐ Whooping Cough	☐ HIV	☐ Hepatitis	☐ Influenza	☐ Shingles
☐ Anemia	☐ AIDS	☐ Diabetes	☐ Pleurisy	☐ Other: ________

Please indicate if you have had any surgeries/operations/hospitalizations:

☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia ☐ Back Surgery ☐ Broken Bones: ___________________

☐ Other: ____

Have you had any previous:

☐ Sports Injuries: ____ When? _______________

☐ Auto-accidents: ____ When? _______________

☐ Work Injuries: ____ When? _______________

Medical conditions: ____

Medications or supplements: ____

Do you smoke? ☐ Y ☐ N ☐ Quit: how long? _____ If smoke, how many packs/day? _____ For how long? ____

How many hours of sleep do you get a night? ____________ Do you feel rested when you wake up? ☐ Y ☐ N

What position do you sleep in? ☐ Side ☐ Back ☐ Stomach

How old is your mattress and pillow? _______________

How often do you exercise? ☐ Daily ☐ Every other day ☐ Weekly ☐ Infrequent ☐ None

Please indicate the level of improvement you expect from treatment: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Please indicate which type of chiropractic care you would like:

☐ Relief care - alleviates your symptoms but not the cause

☐ Corrective Care - alleviates your symptoms or pain and corrects the cause of the problem

☐ Maintenance Care - regular treatment to prevent symptoms from occuring

☐ Unsure, would like Dr. Chudolinski or Dr. Manga to decide which care is best

Head to Toe
Chiropractic and Wellness Centre

Doctor's Notes (please leave this box blank):

Date: / /

X-Rays: ☐ Y ☐ N ☐ Other: ____

Pt. Accepted: ☐ Y ☐ N ☐ Referred: ______________________ Signed: ________________________________

THIS PAGE OFFICE USE ONLY Patient: ______________________ File No.: __________

PHYSICAL EXAMINATION

Posture/Observation

- □ Bruising
- □ Cuts/Scars
- □ Swelling
- □ Rash
- □ Other:

Arches: □ Low □ Normal □ High □ R □ L □ B
Head Carriage: □ Mild □ Mod. □ Severe □ A □ P

Neurological Exam

Reflexes	Upper:	Lower:
Motor	Upper:	Lower:
Sensory	Light:	Sharp / Dull:
Other		

Orthopedic Testing

Valsalva
Kemps

L/S	**C/S**
SLR	Spurling
Fig 4	Jackson
Thomas	Doorbell
ELYs	E.A.S.T.
Hibbs	

Other:

Range of Motion

Active/Passive: Resisted:

Joint / Muscle Palpation

L R Other:

C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
SI

Doctor's Comments

Dx./Ddx.: ____

Treatment:

□ SMT / Activator	□ Extremity Adjustment	□ Joint Mobilization	□ Acupuncture
□ STT/TrPT	□ Ultrasound	□ IFC	□ Thumper
□ Ice or Heat	□ Home exercises	□ Home Ice or Heat	□ Other:

Frequency: □ 1x/wk □ 2x/wk □ 3x/wk □ 1x/2wks □ 1x/3wks □ 1x/month □ Other: _______________

Total Tx. Before Re-evaluation: ______________________

OFFICE USE ONLY Patient Name: ______________________ File No.: __________

Informed Consent to Chiropractic Treatment

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:

- 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;
- 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 spine adjustment is extremely remote;
- There are rare reported cases of disc injuries following cervical and lumbar spine adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Head to Toe
Chiropractic and Wellness Centre

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 Dr. Chudolinski or Dr. Manga 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.

READ BEFORE SIGNING

Dated this ______ day of _______________, 20_____.

___________________________________ Patient Signature

___________________________________ Witness Signature:

OFFICE USE ONLY Patient Name: ______________________ File No.: __________

Informed Consent to Acupuncture Treatment

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including electro-acupuncture by Dr. Chudolinski or Dr. Manga or any other authorized doctor who may be treating when the doctors are away from the office.

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/or bent or stuck needles.

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

I do not expect Dr. Chudolinski or Dr. Manga to be able to anticipate and explain all possible risks and complications. I wish to rely on Dr. Chudolinski or Dr. Manga to exercise judgment during the course of the treatment, which he/she feels at the time, based upon the facts then known, is in my best interests. This also applies to any other authorized doctor who may be treating when the doctors are away from the office. I understand that the results are not guaranteed.

I have read the above 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.

Head to Toe
Chiropractic and Wellness Centre

Note to Female Patients:

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may pregnant, and should I become pregnant at a future date I will inform Dr. Chudolinski or Dr. Manga prior to receiving any acupuncture treatment.

Communicable Diseases by Blood:

I understand that there is a risk of transmitting a communicable disease by blood when acupuncture is performed. Please check off below any that apply to you to the best of your knowledge:

□ HIV/AIDS □ Hepatitis □ Other: ____________________ □ No diseases transmissible by blood

Should I contract a disease communicable by blood at a future date I will inform Dr. Chudolinski or Dr. Manga prior to receiving any acupuncture treatment.

READ BEFORE SIGNING

Dated this ______ day of _______________, 20_____.

___________________________________ ___________________________________

Patient Signature Witness Signature:

Dr. Artur Chudolinski, HBSc, DC
Dr. Jasmin Manga, HBSc, DC