Dr. Howard Kirsh
CHIROPRACTOR

951 Wilson Avenue
#18, Main Floor
Toronto, ON
M3K 2A7
(416) 633-7376

Patient Name: _____ Date:_____

Email: _____ Guideline sent Y N

1. Are you experiencing any of the following symptoms with unknown cause -

- Fever Y N
- Cough Y N
- Shortness of breath Y N
- Difficulty breathing Y N
- Difficulty swallowing Y N
- Loss of taste/smell Y N
- Chills Y N

2. Have you or any member of your household travelled outside of Canada or had close contact with anyone that has travelled in the past 14 days? Y N

3. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID 19? Y N

4. Have you been wearing the required and/or recommended PPE according to the type of duties you were performing? Y N

5. Have you been tested for COVID-19 Y N If yes, when:_____

Upon visit:

Initial	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Dr. Howard Kirsh
CHIROPRACTOR

951 Wilson Avenue
#18 Main Floor
Toronto, ON
M3K 2A7
(416) 633-7376

Name: _____
First Middle Last

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: Home: _____ Bus: _____ Cell: _____

Birth Date: Day: _____ Month: _____ Year: _____ Gender: M ___ F ___

Marital Status: _____ Do you have Extended Health Coverage? Yes ___ No ____

Previous Chiropractor: _____ Last Visit _____

In case of emergency, whom may we contact? _____ Phone #: _____

Whom may we thank for referring you to our office? _____

Email address _____ May we add you to our email list? □ Yes □ No

Health Status

Current Complaint(s):_____

How long has this condition existed? _____ How did this happen?_____

Is condition: □ Job Related □ Auto Related □ Home injury □ Fall □ Other: _____

Date of Accident: _____

Is it getting: □ Worse □ Constant □ Comes/Goes □ Better

Compare this problem at its worst to when you feel great. How does this problem at its worst interfere with;

Your ability to work? _____

Your ability to enjoy your family and social time? _____

Your ability to enjoy hobbies or sports? _____

At its worst, how old does it make you feel? _____

Current Medications _____

Do you suffer from any condition other than that for which you are now consulting us?

_____

Previous surgery/hospitalization: _____

Have you every worn orthotics: _____

Have your children ever had a spinal check up? _____

WHY CHIROPRACTIC CARE?

People go to a Chiropractor for a variety of reasons. Some go for **symptomatic relief** of a condition ***(Relief Care).*** Others are interested in having the cause of the problem as well as the symptoms corrected and relieved ***(Corrective Care)***. Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care ***(Preventative Care)***. These are the 3 phases of care. Your doctor will consider your needs and desires when recommending your schedule of care. Remember that your prepared recommendation is an incorporation of all three phases of care.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Preventative/Maintenance Care (*I would like my body to function at its highest state possible*)
□ Corrective Care (*I want the cause of my problem corrected and relief from symptoms*)
□ Relief Care (*I only want to be relieved of my current symptoms*)

Please read carefully;

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance companies (Charges may apply). However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will become immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, ordering diagnostic x-rays for me by the Doctor of Chiropractic and/or anyone working in this clinic authorized by the Doctor of Chiropractic.

Our Fee Structure

Initial visit	$ 100.00
Re Evaluation	$ 70.00

Fees for your **second** visit:

Report of Findings	$ 70.00

*The doctor will spend time with you to go over your results
(Also includes your first treatment)

Fees for **subsequent** visits:

Subsequent Treatment	$ 50.00

Patient/Guardian's Signature_____ Date_____