ACTIVE COVID19 SCREENING

_____
(Full Name)

1. Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?

2. Do you have a confirmed case of COVID-19 or have you had any close contact with a confirmed case of COVID-19?

3. Do you have any of the following symptoms: fever, new onset of cough, worsening chronic cough, shortness of breath, difficulty breathing, sore throat, difficulty swallowing, decrease or loss of sense of taste or smell, chills, headaches, unexplained fatigue/malaise/muscle aches (myalgias), nausea/vomiting, diarrhea, abdominal pain, pink eye (conjunctivitis), runny nose/nasal congestion without other known cause?

4. If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

By signing below, you are certifying that your answers to all of the above questions are NO

☐ Dr. Cohen and I have discussed the possible risk of COVID19 exposure as a result of attending this office and I choose to proceed with receiving hands on care. Date: _____

_____	_____	_____
Full Name/Legal Gardian	Signature	Date

BEACHES FAMILY CHIROPRACTIC
Dr. Michael Cohen DC
131 Midland Ave, Scarborough, ON M1N 3Z8
tel: (416)500-5437

Privacy Statement

As your chiropractic doctor, my staff and I are bound by law and ethics to safeguard your privacy and the confidentiality of your personal information.

This includes:

- collecting only the information that may be necessary for your care;
- keeping accurate and up-to-date records;
- safeguarding the medical records in my possession;
- sharing information with other health-care providers and organizations on a "need to know" basis where required for your health care;
- disclosing information to third parties only with your express consent, or when necessary for legal reasons; and
- retaining/destroying records in accordance with the law.

Your request for care from me implies consent for our collection, use and disclosure of your personal information for purposes related to your care. As noted above, other purposes require your express consent.

You have the right to see your records. You may also obtain copies of your records – please note that there may be some fees for this service. Please speak to me if you have concerns about the accuracy of your records.

You may ask to receive a copy of our Privacy Policy or view it on the office website at *www.CreatingWellness.ca* If you would like to discuss our privacy policy in more detail, or have specific questions or complaints about how your information is handled, please speak to me and I will try to resolve them.*

Dr. Michael Cohen DC

*If your complaint is not resolved to your satisfaction by my office, you may wish to contact the Information and Privacy Commissioner of Ontario at (416) 326-3333 or 1(800) 387-0073.

Hello. Welcome to Beaches Family Chiropractic, Network Wellness Centre

Congratulations on taking this exciting step towards better health & improved quality of life!

When you begin Network Spinal Analysis Care you will be exploring the incredible healing power of your own body, your own INNATE HEALING POTENTIAL. During this process, Dr. Michael Cohen will be your healing coach. You will have the opportunity to gain a healthier more flexible spine and to develop long-term strategies for RECLAIMING YOUR POWER FOR YOUR HEALTH. Taking responsibility is at the core of health and peace!

Your initial visit to Beaches Family Chiropractic includes a consultation and history, a paraspinal EMG and thermographic exam and a Network Spinal Analysis examination as well as your first gentle Network Spinal Analysis entrainment. A second visit will be arranged to review the results of your exam and to discuss recommendations for care.

My purpose in sharing this statement of clinical objective is to clearly define my approach to Chiropractic, healing, and those I serve in this office. I wish to clearly communicate our responsibilities in this exciting relationship.

The following concepts are central to the way in which I practice Chiropractic. I am pleased to share these ideas with you, so that our purposes can be in alignment from the very beginning. The opinions and concepts shared with you in this document are based on my own beliefs, experiences, teachings and ongoing education which may, or may not; reflect those of other chiropractors and/or the chiropractic profession.

There is an intelligence within each individual which not only keeps that person alive, but also animates, coordinates, repairs, renews, empowers and heals. The nervous system is the main coordinating system and distribution centre for this innate intelligence.

Alteration in the shape, position, tone or tension of the nervous system, at the spinal level, will block, inhibit or redirect the expression of this intelligence.

Spinal cord tension patterns interfere with the proper functioning of the nervous system and its ability to send, receive and coordinate life force and intelligence.

Proper coordination, repair, movement, inspiration, empowerment, healing, cannot be expressed when this life power and intelligence is blocked, altered and/or redirected.

The purpose of the professional care in this office is to assist in the reduction of Adverse Mechanical Spinal Cord Tension (AMCT) and associated vertebral subluxations and to develop and maintain spinal and neural integrity. This empowers a greater communication of this life power and coordinating intelligence. A healthier spine, nervous system and enhanced health and quality of life, is a desired outcome.

Everyone, in spite of specific symptoms or ailments, can benefit from a more flexible, elastic and subluxation-free spine and nervous system.

Symptoms are not necessarily a sign of illness. They can occur to alert the individual of the need for change.

Specific location of symptoms does not correlate to specific nervous system stress or areas of spinal cord tension needing to be reduced. Severity of symptoms does not correlate to severity of mechanical spinal cord tension. The reduction of symptoms is not an effective indicator of improved health.

An individual may have symptoms and not need an entrainment on a particular visit. An individual may have no symptoms and may require extensive entrainments on a particular visit. A person's symptoms are not necessarily in direct relationship to his or her prognosis.

I do not treat specific symptoms, conditions or ailments, other than nervous system stress patterns. I do not imply that any particular entrainment or series of entrainments will have a direct effect on any symptom or condition a person may be presenting. Research studies show improved physical and

(Please Turn Over)

emotional health and well being, reported by thousands of patients receiving Tonal, Non-Linear Network Chiropractic Care.

Your innate intelligence is the true agent of healing, empowerment, coordination, inspiration, movement and joy. Healing is an inside job, coordinated by the same power which develops and renews your body.

By their very intent, various treatments, aimed at reducing symptoms, may interfere with the functioning of the nervous system. This may include drugs such as pain relievers, muscle relaxants, anti-inflammatory compounds and mood altering medication. This can often prolong the time for spinal correction.

Medication levels for a non-flexible body-mind stuck in sickness are not necessarily the same as for a body becoming well.

Consistent with the above concepts, I locate and entrain areas of spinal cord tension using the techniques I believe to be most honoring and effective. I choose to help each individual member of my practice to a greater level of wellness, elasticity, personal growth, empowerment and healing.

OUR CURRENT FEE SCHEDULE AND FINANCIAL POLICY IS AS FOLLOWS:

Initial Consultation/Examination/Report:	$190
Report of Findings/Dynamic Exams:	$45
Subsequent Chiropractic sessions:	$50

We also offer Monthly Wellness **C**hiropractic **A**ctive Life **P**lans as well as Monthly **F**amily Wellness **A**ctive Life **P**lans which are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you at your Report of Findings appointment.

We are committed to providing you with the best chiropractic care possible in a caring and safe environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an **A**ctive **L**ife **P**lan in advance. If you have any questions or concerns about these policies, please feel free to ask us so that we may clarify them for you.

If you have health insurance benefits that contribute towards your chiropractic care, we will give you all of the documentation that you may need to get reimbursed quickly. This includes your diagnosis, prognosis and copies of your records or reports as needed. We have found it is easier for your record keeping and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

I _____ have read this statement of purpose and Office Fee Policy and I understand it's contents. I understand that the spinal entrainments offered in this office are not a replacement for any form of treatment provided by other types of practitioners. I understand that I am not being treated for any condition or symptom other than spinal tension, nerve interference and the associated loss of spinal and neural integrity. This office offers chiropractic as a form of health and wellness care, to promote the natural mechanisms for self healing and empowerment, as compared to specific target treatment.

Signature: _____ **Date:** _____

BEACHES FAMILY CHIROPRACTIC

Network Wellness Centre

Confidential Practice Member Information

Today's Date: month / day / year

First Name: _____ Middle: _____ Last: _____

Date of Birth: month / day / year Age: _____ Sex: M / F

Cell Phone Number: (____) ____ - _____ Home Number: (____) ____ - _____

E-mail Address: _____ ❑ check here to receive our newsletter

Home Address: _____

City: _____ Prov: _____ Postal Code: _____

Occupation: _____ Employer: _____

Marital Status: Married Single Widowed Divorced Separated Partnered

Spouses Name (if applicable): _____ No. of Children: _____

How did you find out about Dr. Michael Cohen and Beaches Family Chiropractic?
❑ phone book ❑ newspaper ❑ advertisement ❑ mailer ❑ signage
❑ referral ❑ other_____

Whom May We Thank For Referring You to This Office? _____

Please state the reason for today's visit. If a recent trauma is involved, please explain:

_____

_____

BEACHES FAMILY CHIROPRACTIC - Network Wellness Centre
131 Midland Ave. Toronto, Ontario M1N 3Z8
www.CreatingWellness.ca
info@CreatingWellness.ca
416-500-5437

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 multi-disciplinary 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:_____ **Name:_____**
(please print) **(please print)**

CCPA.06.05

Dr. Michael Cohen DC. Beaches Family Chiropractic 131 Midland Ave. Scarborough, ON M1N 3Z8

WELCOME TO OUR OFFICE

Name:_____ Date: _____

Have you ever had your spine or nervous system examined professionally? ❑ Yes ❑ No

Is your family currently under chiropractic care? ❑ Yes ❑ No

Have you heard of Network Spinal Analysis ? ❑ Yes ❑ No

If you have any difficulty filling out this form, please ask or mark the question and we can discuss it further during your consultation.

Your healing with Network Spinal Analysis begins with gentle, honoring, light force entrainments to reduce abnormal spinal cord tension. As your body begins to reawaken you may observe many changes in your physical, mental and emotional systems. Whether you have come to us to rid yourself of a pain, to increase your present state of awareness or to increase the flexibility of your nervous system and improve your quality of life... Congratulations, you are on your way!

Present Reason for Consulting our Office? (please choose the **MOST** appropriate answer)
❑ Maximizing personal health potentials ❑ Improving family and/or community health
❑ Preventing disease, symptoms or infirmities ❑ Disease, symptoms or infirmities

What concerns you currently about your health? *(Please include all issues which you feel you have had, currently do have or concern you about your health in the future.)*

1. _____
2. _____
3. _____

When did these health concerns begin and have you been advised or had treatment?

_____

What were you told? _____
What was done and did it work? _____
What was different about you after the treatment? _____
What was different about your condition after the treatment? _____
Since this happened:

1) Have you changed habits? ❑ Yes ❑ No
2) Held or touched part of your body more or differently? ❑ Yes ❑ No
3) Moaned, cried or made sounds that you usually do not make? ❑ Yes ❑ No

Which best describes your current feelings about yourself and your situation?

A) I feel helpless, like little or nothing works
B) This is terrible, really bad, I am scared, and hope you can fix it for me.
C) I feel stuck, and can't help myself right now
D) I deserve more than what I have been experiencing, and would like you to assist me in my healing.
E) Anything else? _____

Please grade the level to which your health concern(s) affects these aspects of your functioning and quality of life.

(0) - Does not seem to affect me (1) - It seems to slightly affect me
(2) - It seems to moderately affect me (3) - It seems to drastically affect me

_____ Affect on work _____ Affect on rest/sleep _____ Concern about health
_____ Affect on social life _____ Affect on walking _____ Affect on sitting
_____ Affect on exercise _____ Affect on eating _____ Affect on love life

How would you describe your:
DIET ❑ Poor ❑ Good ❑ Excellent REST ❑ Poor ❑ Good ❑ Excellent
EXERCISE ❑ Poor ❑ Good ❑ Excellent STRESS LEVEL ❑ High ❑ Some Stress ❑ Not Stressed

Have you had or do you receive any of the following vehicles towards growth, healing and development: *chiropractic, massage, bodywork, kinesology, yoga, pilates, chelation, homeopathy, ayurevedic, somato-respiratory integration, acupuncture, Qi Gong, oriental medicine, music, dance sound or light therapy, psychotherapy, rebirthing, breath work, movement therapy, Other?* _____

Do you have an exercise, meditation, prayer, nutritional, or dietary program? ***(if YES,circle)***
When stressed, how do you centre yourself or re-group? _____
Is there some aspect of your life that very much pleases you, brings you joy, or helps you to feel better about yourself? _____

The practice of chiropractic care is based on the location and correction of nervous system interference and tension. The interferences are caused by any stress your body can not perceive, adapt to or recover from. These stresses may be physical, chemical, or emotional in nature.

PHYSICAL HISTORY:

Birth Stress: Was your mother ill during pregnancy? _____
Was your birth: ❑ natural ❑ drug induced ❑ Forceps or suction
❑ C-section ❑ Breech ❑ prolonged

The spine is the most neglected part of a child's health. 80% of children have nerve interference due to birth.

General physical trauma: Please list any injuries which may have occurred from birth to present. Please include dates of the incidents. Be sure to list any falls, play ground accidents, sports injuries, car accidents, broken bones, extensive dental work, repetitive movements.

_____
_____
_____

What surgeries have you had? _____

Do you exercise? ❑ Yes ❑ No if so, please describe _____

Please rate your sleep: hours per night ❑ 4-6 ❑ 6-8 ❑ 8-10 ❑ 10+ (___)hrs.
Do you wake well rested? ❑ Yes ❑ No
Do you wake from sleep during the night? ❑ Yes ❑ No describe _____

Have you ever been knocked unconscious: ❑ Yes ❑ No ❑ don't know
If so, for how long: _____

CHEMICAL HISTORY:

List all chemicals you are taking and their purpose (include **ALL** prescriptive and non prescriptive drugs such as birth control, aspirin, cold tablets, etc.) _____

_____

Have you ever had radiation or chemotherapy? _____

What reactions have you had to medications or vaccinations? _____

_____

How often do you consume the following? **N**(never) **D**(daily) **W**(weekly) **M**(monthly) **S**(sometimes)

_____Alcohol _____Coffee _____Tea _____Artificial Sweeteners

_____Pop _____Refined Sugar _____Tabacco _____Organic Foods

EMOTIONAL HISTORY:

The following areas of stress can cause a misaligned vertebra (subluxation) resulting in nerve stress. Do you recognize any of these stresses? Please circle when you experienced these stresses: **C** (child), **T** (teenager), **A** (adult) or **N** (not at all) and explain.

Relationships	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Fast-paced life	C	T	A	N	_____
Concealing feelings	C	T	A	N	_____
Quick tempered	C	T	A	N	_____
Verbal abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Loss of Loved one	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____

How would you grade your emotional/mental health?

❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Getting Better ❑ Getting Worse

FAMILY HEALTH HISTORY:

Is there any family history of the following? if so, please describe:

❑ cancer_____

_____

❑ diabetes _____

_____

❑ heart disease _____

_____

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE

Please use this scale for questions 1 and 2

A - very important to me **B - important to me**
C - not so important to me **D - does not apply**

1. Of the following five choices, which is currently of most interest to you and how do you hope to benefit from care in this office? In a published study of over 2800 patients under Network Chiropractic care, conducted within the Medical College at the University of California - Irvine, patients reported an overall improvement in all of the categories of health and wellness listed below.

____Improvement in my physical symptoms
____Improvement of emotional/mental symptoms
____Improvement of my ability to react or respond to stress
____Improvement in enjoyment of life and ability to make constructive choices
____Overall improved quality of life

2. For a slightly longer term goal, how do you hope to benefit from care in this office?

____Improvement of my physical symptoms
____Improvement of emotional/mental symptoms
____Improvement of my ability to react or respond to stress
____Improvement in enjoyment of life and ability to make constructive choices
____Overall improved quality of life

What is your commitment to improving your health (Scale 0-10) _____

Is there any area of your life (work, family, dietary, etc.) that you feel would impair your opportunity to reach full glowing health? _____
_____

Is there anything else you may wish to share which may help us to better understand you?
_____
_____

When communicating to you about your spine, nervous system, health and wellness
(choose ONE by circling your preference)

a) Mostly speak with me about the clinical findings and tell me about the changes I am making
b) Mostly show me in written form the clinical findings, and let me see the changes that I am making
c) Mostly let me get a sense of the clinical work, help me feel the difference in my body

What would motivate you to tell others about the care you receive in this office, and encourage others to get under care? _____

Thank you for choosing our office. We are looking forward to helping you to be successful in your ability to develop a healthy spine and nervous system. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.