

Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Birth date (D/M/Y) \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_

Postal Code \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

May we contact you at work?  Yes  No Work # \_\_\_\_\_ Extension \_\_\_\_\_

Email Address: \_\_\_\_\_  Yes! I would you like to receive your  
Monday Morning Health Tips.

Who referred you to our office? \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

If you have children, how many? \_\_\_\_\_ Their names \_\_\_\_\_

Do you have pets? If so, what species? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to you \_\_\_\_\_

Contact # \_\_\_\_\_ Alternative contact # \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Company Name \_\_\_\_\_ Location \_\_\_\_\_

Do you have extended healthcare benefits?  Yes  No Insurance Company: \_\_\_\_\_

Benefits are personal  or from work

Have you had previous chiropractic care?  Yes  No When and where? \_\_\_\_\_

Were x-rays taken?  Yes  No If yes, when? \_\_\_\_\_

Family doctor \_\_\_\_\_

Have you been treated by a physician for any health condition in the past year?  Yes  No

Describe condition: \_\_\_\_\_

Date of last physical: \_\_\_\_\_

Surgical operations and years: \_\_\_\_\_

Are you now taking any medication?  Yes  No

Name and Reason \_\_\_\_\_

Are you now taking any vitamins/herbs/homeopathies/other?  Yes  No

Name and Reason \_\_\_\_\_

Are you pregnant?  Yes  No If yes, what month? \_\_\_\_\_

Is your visit due to an accident or injury?  Yes  No

If yes, describe \_\_\_\_\_

What is your major health concern? \_\_\_\_\_

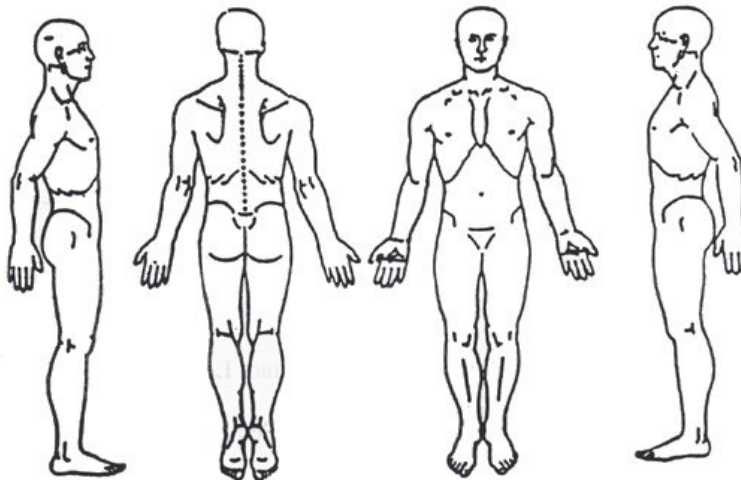
For how long have you been experiencing this? \_\_\_\_\_

Is this condition becoming worse?  Getting worse  Improving  Intermittent  Constant

Where is the problem? Please use the illustrations and lines below to explain.

Front \_\_\_\_\_

Back \_\_\_\_\_



Do you have:  Pain  Numbness  Tingling  Aches

Is your pain:  Sharp  Dull  Throbbing  Constant  Intermittent

Are your symptoms affected by:  Sitting  Standing  Walking  Bending  Lying down  Weather

Please Explain \_\_\_\_\_

Do you feel:  Cramps  Burning  Swelling  Stiffness  Other \_\_\_\_\_

Is this concern interfering with:  work  sleep  daily routine  Play  other \_\_\_\_\_

Please explain \_\_\_\_\_

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms                      1   2   3   4   5   6   7   8   9   10

Other health professions seen for this health concern: \_\_\_\_\_

Do you have, or have you had, any of the following (please check all that apply)

- |                                    |                                  |                                      |                                          |                                   |
|------------------------------------|----------------------------------|--------------------------------------|------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps   | <input type="checkbox"/> Influenza   | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Pleurisy  | <input type="checkbox"/> Polio   | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Depression  | <input type="checkbox"/> Whooping cough  | <input type="checkbox"/> Anemia   |
| <input type="checkbox"/> Eczema    | <input type="checkbox"/> Measles | <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Heart disease   | <input type="checkbox"/> Rashes   |

If you have ever been diagnosed with another disease or condition, please describe

\_\_\_\_\_

Do you use:  Coffee  Tea  Artificial sweeteners  Sugar  Alcohol  Cigarettes  Recreational drugs

Have you ever suffered from (please check all that apply)

- |                                                  |                                                   |                                             |                                              |
|--------------------------------------------------|---------------------------------------------------|---------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Neck pain               | <input type="checkbox"/> Stuffy nose              | <input type="checkbox"/> Discolored urine   | <input type="checkbox"/> Low back pain       |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Gas/Bloating after meals | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Heartburn               | <input type="checkbox"/> Migraines                | <input type="checkbox"/> Weight loss        | <input type="checkbox"/> Colitis             |
| <input type="checkbox"/> Arm/back tingling       | <input type="checkbox"/> Poor appetite            | <input type="checkbox"/> Irritable bowel    | <input type="checkbox"/> Shoulder pain       |
| <input type="checkbox"/> Excessive appetite      | <input type="checkbox"/> Black or bloody stools   | <input type="checkbox"/> Hand pain/tingling | <input type="checkbox"/> Nervousness         |
| <input type="checkbox"/> Constipation            | <input type="checkbox"/> Leg pain/tingling        | <input type="checkbox"/> Confusion          | <input type="checkbox"/> Hemorrhoids         |
| <input type="checkbox"/> Jaw pain                | <input type="checkbox"/> Depression               | <input type="checkbox"/> Liver problems     | <input type="checkbox"/> Chest pain          |
| <input type="checkbox"/> Dental problems         | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Lung problems      | <input type="checkbox"/> Excessive thirst    |
| <input type="checkbox"/> Paralysis               | <input type="checkbox"/> Heart problems           | <input type="checkbox"/> Frequent nausea    | <input type="checkbox"/> Tingling            |
| <input type="checkbox"/> Abnormal blood pressure | <input type="checkbox"/> Vomiting                 | <input type="checkbox"/> Numbness           | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Prostate problem        | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Ankle swelling     | <input type="checkbox"/> Breast pain/lump    |

- |                                          |                                            |                                               |                                              |
|------------------------------------------|--------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Cold extremities  | <input type="checkbox"/> Cramps               | <input type="checkbox"/> Loss of sleep       |
| <input type="checkbox"/> Blurred vision  | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Difficulty hearing   | <input type="checkbox"/> Vision problems     |
| <input type="checkbox"/> Bladder trouble | <input type="checkbox"/> Ear pain          | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Excessive urination |

If applicable, date of last menstrual period \_\_\_\_\_

Past injuries can affect present health (please check all that apply)

- |                                              |                                                  |                                                |                                            |
|----------------------------------------------|--------------------------------------------------|------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Falls/Accidents     | <input type="checkbox"/> Head injuries           | <input type="checkbox"/> Fights                | <input type="checkbox"/> Sports injuries   |
| <input type="checkbox"/> Broken bones        | <input type="checkbox"/> Dislocations            | <input type="checkbox"/> Spinal tap            | <input type="checkbox"/> Surgery           |
| <input type="checkbox"/> Traction            | <input type="checkbox"/> Use(d) a cane or walker | <input type="checkbox"/> Extensive dental work | <input type="checkbox"/> Dental appliances |
| <input type="checkbox"/> Knocked unconscious |                                                  |                                                |                                            |

If yes to any of the above, please describe \_\_\_\_\_

In your own words what do chiropractors do? \_\_\_\_\_

Do you know what spinal nerve stress/subluxation is?  yes  no

If yes, please describe \_\_\_\_\_

If yes, do they use chiropractic for:  health maintenance/optimization  health problems  both

Are you seeking chiropractic for:  health maintenance/optimization  health problems  both

What would you like to gain from chiropractic care? \_\_\_\_\_  
 \_\_\_\_\_

How long do you think it will take for your symptoms to go away? \_\_\_\_\_

How long do you think it will take to correct the problem? \_\_\_\_\_

Are there other health concerns or anything else you'd like us to know about you?  yes  no

If yes, please tell us. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Notes \_\_\_\_\_  
 \_\_\_\_\_

## 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 the 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 (or Legal Guardian)

\_\_\_\_\_  
Signature of Witness

Name: \_\_\_\_\_  
(please print)

Name: \_\_\_\_\_  
(please print)