CONFIDENTIAL PATIENT CASE HISTORY

Name _____ **Health Card #** _____

Address _____**City** _____ **Province** _____ **Postal Code** _____

Home Number_____**Work Number**_____**Cell Number**_____

Age _____ **Birth date** _____(mm/dd/yy)_ Sex **M** □ **F** □ **Marital Status: M S W D**

Work Address _____ **Occupation** _____

Referred by _____

e-mail address _____**USED FOR APPOINTMENT CONFIRMATIONS AND REMINDERS**

Is this a □ **Worker's Compensation Injury?** □ **Motor Vehicle Accident? If Yes Claim Number**_____

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case. Thank You.

Have you had previous chiropractic care? _____ By whom?_____

When? _____ For What Condition?_____

List Surgical Operations and Years_____

Drugs you now take or have taken in the past year: □ Pain Killers □ Muscle relaxants □ Birth Control Pills □ Aspirin
□ Corticosteroids □ blood thinners □ Other _____

Do you smoke: □ Yes □ No If Yes - how much? _____

Have you been in an auto accident? □ Yes □ No When? _____

Describe: _____

Have you ever had x-rays taken of your spine? □ Yes □ No When? _____

Do you participate in a regular exercise program? □ Yes □ No Describe: _____

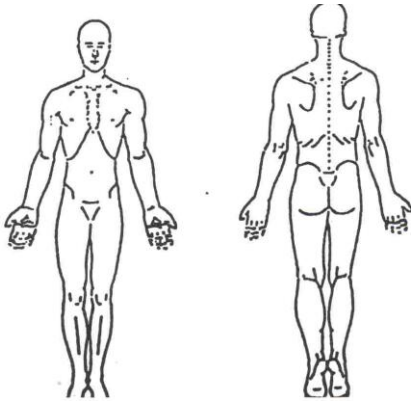
Are you currently pregnant? □ Yes □ No If Yes - how many weeks _____

Have you been diagnosed with any of the following?
□ Diabetes □ Arthritis □ Stroke □ High Cholesterol
□ High Blood Pressure □ Cancer □ Transcient Ischemic Attacks □ Other _____

Date of Last Physical Examination: _____ Name of Family Medical Doctor**:**_____

Approximate Height _____Weight _____

Please mark your areas of pain on the figures below:



Family Health History:
We are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:
Children (& Ages) _____
_____
_____
Spouse _____
Mother_____
Father _____
On a scale of 1 - 10, describe your stress level (1= None/ 10= Extreme):
Occupational _____ Personal _____
On a scale of Poor, Good, Excellent, describe your:
Diet _____Exercise _____Sleep _____General Health_____

As a full spectrum Chiropractic office, we focus on your potential to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. The following information addresses the health concerns that brought you to our office:

NAME: _____ DATE:_____

If you have no symptoms or complaints, and are here for wellness services, please check here □.
Others need to complete the following questions:

1. Reason for consulting the clinic: _____
_____
_____

2. How long have you had your primary complaint? _____
_____

3. How did it start?_____
_____
_____

4. Is it: □ improving □ staying the same □ getting worse □ comes and goes

5. Is it worse in the: □ morning □ afternoon □ evening □ night

6. What makes it worse? (e.g. sitting/stand/lifting) _____
_____
_____

7. What makes it better? (e.g. rest/medication/ice/heat)_____
_____

8. If you are employed, please describe what activities you do on a daily basis(for example, lifting, typing, prolonged standing, sitting):
_____
_____

9. Yes, it interferes with: □work □ sleep □hobbies □ leisure activities

10. Previous types of care: □Chiropractic □ Massage
□Physical Therapy □Medical Doctor □ Specialist
□Other _____

Health Conditions - please circle any symptoms you have experienced during the past 12 months

Respiration	**Gastrointestinal**	**Cardiovascular**
chronic cough	**nausea**	**high blood pressure**
chest pain	**vomiting**	**hardening of arteries**
difficult breathing	**diarrhea**	**swollen ankles**
asthma	**indigestion**	
	ulcers	
	heartburn	
	constipation	

Neurological	**Muscle and Joints**	
visual disturbances	**stiff neck**	**arthritis**
co-ordination difficulties	**backache**	**spinal curvature**
dizziness	**neck pain**	**faulty posture**
slurred speech	**swollen joints**	
headache	**foot trouble**	
facial numbness	**pain in shoulders**	
difficulty swallowing	**loss of balance**	

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a.) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.

b.) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c.) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____day of _____, 20_____.
Day Month Year

_____ _____
Patient Signature(Legal Guardian) **Name (Please Print)**

_____
Witness to Signature