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Chiropractic New Patient Intake Form

Personal History

Name: _____ Birthdate: _____ Gender: ☐M ☐F

Address: _____ City: _____ Province: _____

Postal Code: _____ Email Address: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Preferred Phone: ☐H ☐W ☐C

Extended Health Care? ☐Y ☐N Carrier name:_____ Group #: _____ ID #: _____

Number of children/Ages: _____ Whom may we thank for referring you? _____

Occupation: _____ Emergency Contact Name: _____ Phone #: _____

Name of Family Physician: _____ Phone #: _____

May we contact your physician about your health? ☐Y ☐N Height: _____ Weight: _____

Current Health Condition

Current Complaint(s): _____ Onset Date: _____

Have you seen other Doctors for this condition?: ☐Y ☐N If Yes, Doctor's Name: _____

Type of Treatment: _____ Results: _____

Have you had a condition like this before? ☐Y ☐N Details: _____

What do you think caused this condition? ☐Job ☐Car Accident ☐Home Injury ☐Fall ☐Other: _____

Is this a Worker's Compensation Claim? ☐Y ☐N Is this an Auto Accident Case? ☐Y ☐N

What makes the condition worse? ☐Sneezing ☐Coughing ☐Defecation ☐Sitting ☐Walking ☐Stairs ☐Bending ☐Standing ☐Lifting ☐Other: _____

What makes your condition feel better? ☐Bed Rest ☐Ice ☐Heat ☐Massage ☐Meds ☐Other: _____

Since your condition began, is it getting: ☐Worse ☐Better ☐Comes and Goes ☐No Change

Type of pain: ☐Dull Ache ☐Sharp ☐Tingling ☐Stabbing ☐Burning Pain is: ☐Constant ☐Intermittent

Please place an "X" on the grade below, indicating the severity of your pain.

0 _____ 10

No pain Most pain ever felt

Does this problem interfere with: Work? ☐Y ☐N Family or Social Time? ☐Y ☐N Sleep? ☐Y ☐N

Do you currently wear custom orthotics/ shoe inserts? ☐Y ☐N If Yes, from where? _____

If you do not get this problem corrected, do you think it will get worse over the next five years? ☐Y ☐N

Current Medications: _____

Do you suffer from any other conditions? _____

Sleep Position? ☐Side ☐Back ☐Stomach Mattress Age: _____ Physical activities? _____

Have you had X-rays or other imaging taken? ☐Y ☐N If Yes, Where? Results? _____

Past Health History

Major Surgery/operations: ☐Back Surgery ☐Shoulder ☐Knee/Hip ☐Broken bones ☐Other: _____

Childhood Traumas: _____ Sports or other injuries: _____

Motor Vehicle Accidents: _____ Work Injuries: _____

Hospitalizations / Cardiovascular Disease / Cancer / Thyroid Condition / Other Major Illness: _____

Previous Chiropractic Care: ☐None ☐Doctor's name and approx. date of last visit: _____

Family Health History

Does any member of your family suffer the same condition? ☐Y ☐ N If Yes, Whom: _____

Is there any important medical history in your immediate family (Parents, Grandparents, and Siblings)?

☐Heart Disease/Stroke: _____ ☐Diabetes: _____ ☐Thyroid: _____

☐Cancer: _____ ☐Other: _____

Signs and Symptoms

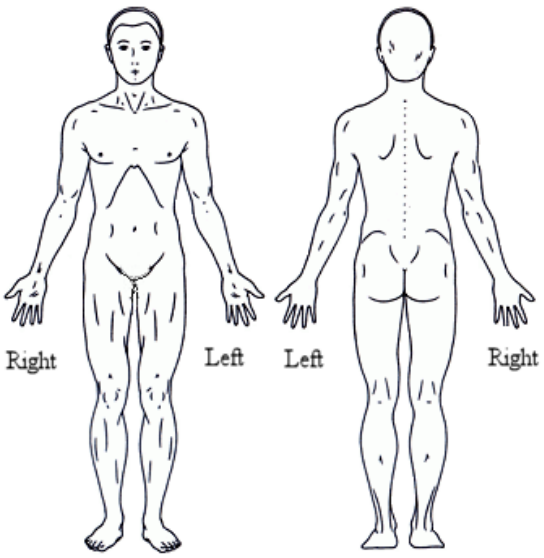
When there is no interference, your nervous system controls the healthy function of virtually every cell, organ, and system in the body. Carefully read the list below and check any conditions that you have experienced in the last 6 months. While some of the conditions may seem unrelated to the purpose of your visit, always remember that nervous system interference may express itself in many ways.

☐ Headaches
☐ Migraines
☐ Dizziness
☐ Fatigue
☐ Head Colds
☐ Vision Problems
☐ Hearing Problems
☐ Sinus Problems
☐ Common Cold
☐ Allergies
☐ Runny Nose
☐ Sore Throat
☐ Tonsillitis
☐ Hoarseness
☐ Laryngitis
☐ Stiff neck
☐ Cough
☐ Upper Arm Pain
☐ Tennis Elbow
☐ Wrist, hand & finger numbness
☐ Shortness of breath
☐ Difficulty breathing
☐ Asthma
☐ Heart Conditions
☐ Chest Pains
☐ Bronchitis
☐ Pneumonia, Congestion
☐ Gallbladder Conditions
☐ Hiatal Hernia
☐ Blood Pressure Problems
☐ Liver Conditions

☐ Jaundice
☐ Skin Conditions, acne
☐ Stomach Problems
☐ Indigestion
☐ Heartburn
☐ Gastritis
☐ Ulcers
☐ Blood Sugar Problems
☐ Kidney Problems
☐ Gas Pains
☐ Chronic Tiredness
☐ Irritable Bowel
☐ Constipation/Diarrhea
☐ Hernias
☐ Sterility
☐ Bladder Problems
☐ Menstrual Problems/Cramps
☐ Bed Wetting
☐ Knee Pains
☐ Sciatica
☐ Low Back Pain
☐ Difficult or painful urination
☐ Numbness in Legs
☐ Poor Circulation in Legs
☐ Shin Splints
☐ Swollen Ankles
☐ Weak Arches
☐ Leg Cramps or Cold Feet
☐ Sacroiliac Problems
☐ Hemorrhoids
☐ Pain at the end of the Spine

Please outline on the diagram the area of your discomfort and any radiation of pain using the appropriate symbol.

Numbness	Pins and Needles	Burning	Ache	Stabbing
- - - -	OOOO	XXXX	****	/ / / /



I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow the Doctor of Chiropractic to examine me for further evaluation. I also agree to payment for all services rendered.

Patient Signature _____ Date_____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

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Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor