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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: _____

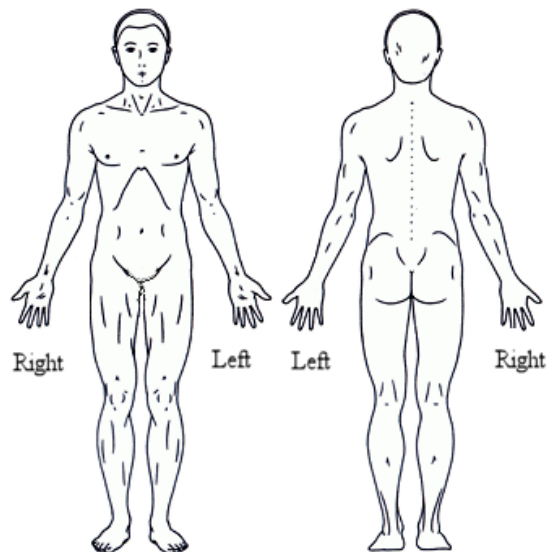
Signs and Symptoms

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.

- | | |
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| <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Fatigue <input type="checkbox"/> Head Colds <input type="checkbox"/> Vision Problems <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Common Cold <input type="checkbox"/> Allergies <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sore Throat <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Hoarseness <input type="checkbox"/> Laryngitis <input type="checkbox"/> Stiff neck <input type="checkbox"/> Cough <input type="checkbox"/> Upper Arm Pain <input type="checkbox"/> Tennis Elbow <input type="checkbox"/> Wrist, hand & finger numbness <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Conditions <input type="checkbox"/> Chest Pains <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia, Congestion <input type="checkbox"/> Gallbladder Conditions <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Blood Pressure Problems <input type="checkbox"/> Liver Conditions | <ul style="list-style-type: none"> <input type="checkbox"/> Jaundice <input type="checkbox"/> Skin Conditions, acne <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Indigestion <input type="checkbox"/> Heartburn <input type="checkbox"/> Gastritis <input type="checkbox"/> Ulcers <input type="checkbox"/> Blood Sugar Problems <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Gas Pains <input type="checkbox"/> Chronic Tiredness <input type="checkbox"/> Irritable Bowel <input type="checkbox"/> Constipation/Diarrhea <input type="checkbox"/> Hernias <input type="checkbox"/> Sterility <input type="checkbox"/> Bladder Problems <input type="checkbox"/> Menstrual Problems/Cramps <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Knee Pains <input type="checkbox"/> Sciatica <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Difficult or painful urination <input type="checkbox"/> Numbness in Legs <input type="checkbox"/> Poor Circulation in Legs <input type="checkbox"/> Shin Splints <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Weak Arches <input type="checkbox"/> Leg Cramps or Cold Feet <input type="checkbox"/> Sacroiliac Problems <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> 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 _____

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)

Signature of patient (or legal guardian)

Date: _____ 20____

Signature of Chiropractor

Date: _____ 20____