Chiropractic For Life

Welcome to our Clinic! - New Patient Intake Form

Name _____ Preferred Name _____

Birthdate (D/M/Y) _____ Age _____ Sex F M

Address _____ Unit _____

City _____ Province _____ Postal Code _____

Home # _____ Cell #_____

May we contact you at work? □ Yes □ No Work # _____Extension _____

May we email you? □ Yes □ No Email Address:_____

□ Yes! I would like to receive your Monday Morning Health Tips!

Who referred you to our office or how did you hear about us? _____

Marital Status _____ Spouse's Name _____

If you have children, how many? _____ Their names_____

Do you have pets? If so, what species? _____

Emergency Contact Person _____ Relationship to you_____

Contact Phone # _____ Alternative contact # _____

What is your occupation? _____

Company Name _____

Do you have extended healthcare benefits? □ Yes □ No 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 _____ Date of last physical _____

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

Describe condition _____

Surgical operations and years _____

Are you taking any medication? □ Yes □ No Name of medication and reason_____

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

Name and reason_____

Do you have any allergies?_____

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? _____

When was the onset of your health concern?_____

How long have you been experiencing this? _____

What is the frequency of your pain (does it come in episodes)? _____

Is this condition: □ Getting worse □ Staying the same □ Improving

Where is the problem? Please use the illustrations and lines below to explain. **Place an X on the diagram in the areas that you are experiencing pain. Use the lines to describe the painful area.**

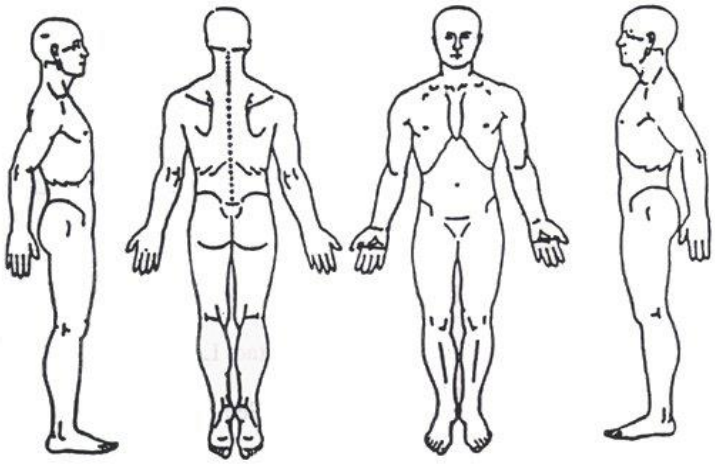
Front _____

Back _____

Right Side _____

Left Side _____

Head and Face _____



Do you have: □ Pain □ Numbness □ Tingling □ Aches □ Soreness □ Tenderness □ Tightness

□ Cramps □ Burning □ Swelling □ Stiffness □ Shooting pain □ Other_____

Is your pain: □ Sharp □ Dull □ Throbbing □ Constant □ Intermittent □ Pinching □ Intense

Does the pain travel anywhere (ie: into the arms/hands, legs/feet)? _____

Do your symptoms increase with any of the following? □ Sitting □ Standing □ Walking □ Bending

□ Twisting □ Lying down □Standing up from sitting □ Weather □ Other_____

Is this concern interfering with any of the following? □ Work □ Sleep □ Daily routine

□ Play/Hobbies □ Other - Please Explain _____

Is there anything you can do to relieve the pain? _____

On a scale of 1-10 (1 being the least, 10 being the most), please rate the severity of your symptoms:

1 2 3 4 5 6 7 8 9 10

Do you have any other associated symptoms? _____

What do you do for exercise/movement? _____

What position do you sleep in? **(Check multiple if needed)**: □ Back □ Left Side □ Right Side □ Stomach

How is your diet/nutrition? Are you on a special diet (ie: vegan/vegetarian/paleo/etc)? _____

_____

Other health professionals seen for this health concern: _____

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

□ Pneumonia	□ Mumps	□ Influenza	□ Rheumatic fever	□ Smallpox
□ Pleurisy	□ Polio	□ Chicken pox	□ Thyroid disease	□ Diabetes
□ Epilepsy	□ Cancer	□ Depression	□ Whooping cough	□ Anemia
□ Eczema	□ Measles	□ Arthritis	□ Heart disease	□ Rashes

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

_____

Do you use:

□ Coffee □ Tea □ Artificial sweeteners □ Sugar □ Alcohol □ Cigarettes □ Recreational drugs

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

□ Fever □ Night Sweats □ Unexplained weight loss/gain □ Excessive fatigue/malaise

□ Loss of sleep □ Motor/sensory disturbance (ie: muscle weakness, paresthesia, numbness, etc)

□ Blurred vision □ Sudden loss of vision □ Visual changes (ie: floaters, changes in colour vision)

□ Dizziness □ Headaches □ Migraines □ Hearing loss □ Tinnitus/Ringing in ears

□ Loss of smell □ Loss of taste □ Unexplained skin conditions (ie: rashes, lesions, ulcers)

□ Difficulty or pain with breathing □ Difficulty inhaling deeply □ Increased coughing

□ Sputum/mucus in cough □ Chest pain □ Heart palpitations □ Irregular heartbeat □ Fainting

□ Cold extremities □ High or low blood pressure □ Depression □ Anxiety □ Appetite changes

□ Nausea/vomiting □ Excessive thirst □ Abdominal pain □ Changes in urine output or colour

□ Increased urgency/frequency/pain □ Changes in bowel habits (ie: constipation, diarrhea, etc)

If applicable, date of last menstrual period: _____

If applicable, date of children's births: _____

If applicable, date of menopause: _____

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

□ Falls/Accidents	□ Head injuries	□ Fights	□ Sports injuries
□ Broken bones	□ Dislocations	□ Spinal tap	□ Surgery
□ Traction	□ Concussions	□ Extensive dental work	□ Dental appliances
□ Unconsciousness	□ Use(d) a cane or walker		

If yes to any of the above, please describe: _____

Is there any family history of any conditions the Doctor should know about? (ie: cancers, strokes, Diabetes, blood pressure/heart problems, scoliosis, other conditions that may be genetic, etc)?

_____

_____

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 the doctor to know about? □ Yes □ No

If yes, please tell us: _____

_____

_____

Notes _____

_____

_____

_____

_____

_____

Chiropractic For Life

CONSENT TO CHIROPRACTIC TREATMENT

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.
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 a 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 changes in your condition or any new conditions that arise.

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.

Patient Name:_____ Date: _____ 20____

Signature of patient (or legal guardian): _____

Signature of Chiropractor: _____ Date: _____ 20____

Chiropractic For Life

Acupuncture Intake Form

Which body part do you want to have treated with acupuncture? _____

Have you ever had acupuncture treatments done in the past? NO _____ YES _____

If YES, for which body parts and/or conditions? _____

Did you have any adverse reactions to the needles (such as increased redness, fatigue, drowsiness, etc)?

_____

Do you have any allergies to metal? NO _____ YES _____

If YES, to which metals? _____

Do you bruise easily? NO _____ YES _____

If YES, is it due to a known bleeding disorder? _____

Are you taking any anti-coagulants (blood thinners) or other medications? NO _____ YES _____

If YES, what medication is it? _____

Do you have a decreased bone density? NO _____ YES _____

If YES, when was the last time your bone density was checked? _____

What was the result of the bone density scan (DEXA)? _____

Are you scared or feel uneasy about the use of needles? NO _____ YES _____

If YES, any additional comments? _____

Do you experience fainting or seizures? NO _____ YES _____

If YES, how often do you experience it? _____

Do you have a pacemaker or any other electrical devices? NO _____ YES _____

If YES, what is the device? _____

Are you pregnant, suspect you may be pregnant or are trying to conceive? NO _____ YES _____

Any additional concerns/comments: _____

Chiropractic For Life

CONSENT TO ACUPUNCTURE

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

I consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including electro-acupuncture by the authorized doctor in the clinic.

The risks associated with acupuncture treatment vary according to each patient's condition, as well as the location and type of treatment. I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized and packaged needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, which is in my best interests. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

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

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

Please read the entire form before signing.

Patient Name:_____ Date: _____ 20____

Signature of patient (or legal guardian): _____

Signature of Chiropractor: _____ Date: _____ 20____