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Patient Health Record

On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specfic stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

About You!

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ dd/mm/yyyy Age: _____ ◯ Male ◯ Female

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Occupation: _____

Would you be interested in receiving the following through email:

◯ Newsletters ◯ Appointment Reminders ◯ None

Marital Status: ◯ Married ◯ Common Law ◯ Single ◯ Separated ◯ Divorced ◯ Widowed

Name of Spouse: _____ # of Children: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Alberta Health Care #: _____

Who can we thank for referring you to our office? _____

Your Health Care Team

Family Doctor: _____ Physiotherapist: _____

Naturopath: _____ Midwife: _____

OB/GYN: _____ Doula: _____

Massage Therapist: _____ Other: _____

Have you had xrays? ◯ Xrays ◯ MRI ◯ Ultrasound ◯ CT

When? _____ Where? _____

Were you aware that:

Doctors of Chiropractic work with the nervous system? ◯ Yes ◯ No

The nervous system controls all bodily functions and systems? ◯ Yes ◯ No

Chiropractic is the largest natural healing profession in the world? ◯ Yes ◯ No

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ◯ Yes ◯ No

Reason for this Visit

Describe the purpose of this visit: _____

Is this visit due to or in any way related to:

◯ Job ◯ Sports ◯ Auto Accident ◯ Fall ◯ Chronic Discomfort ◯ Injury ◯ Pregnancy ◯ Other

If job related, have you reported your accident to your employer? ◯ Yes ◯ No

Will this visit be part of a WCB Claim? ◯ Yes ◯ No Will this visit be part of a MVA Claim? ◯ Yes ◯ No

When did this condition begin? _____

How did it occur? _____

Has this condition: ◯ gotten worse ◯ gotten better ◯ stayed the same ◯ comes and goes

Does this condition interfere with: ◯ work/school ◯ sleep ◯ daily routine ◯ athletic activities

What activities make it worse? _____

What activities make it better? _____

Have you seen anyone else for this condition? ◯ Yes ◯ No

Doctor or Clinician's Name: _____ Treatment: _____

Result: _____

Experience with Chiropractic

Have you been adjusted by a Chiropractor before? ◯ Yes ◯ No How long ago? _____

Reason for visits? _____

Doctor's Name: _____ Date of last visit? _____

Were you adjusted: ◯ manually ◯ with instruments ◯ both

Has any adult in your family seen a Chiropractor? ◯ Yes ◯ No

Has any child in your family seen a Chiropractor? ◯ Yes ◯ No

Mark the areas on the body diagrams where you have pain/numbness, using the following symbols: X = Pain O = Numbness

Rate your pain on the below scale (mark with an X)

Pain Today

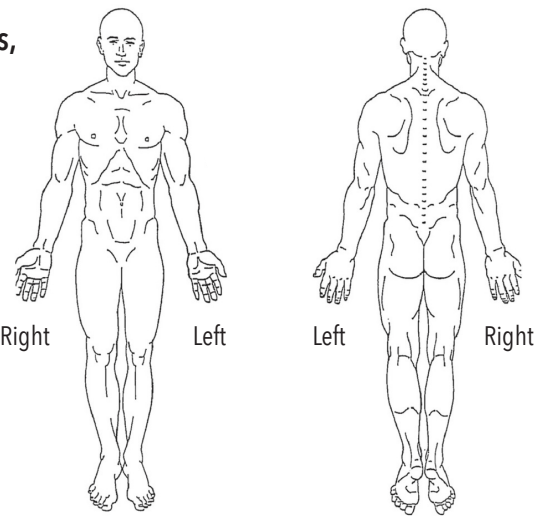
0 ——————————— 10

none worst

Least (pain in last 2 weeks)

0 ——————————— 10

none worst



Health Conditions

Please CHECK any of the below conditions you are experiencing currently, and UNDERLINE those you have experienced in the past:

GENERAL
- ○ Fever
- ○ Sweats
- ○ Loss of sleep
- ○ Fatigue
- ○ Nervousness
- ○ Alcohol / drug abuse
- ○ Weight loss
- ○ Weight gain

NEUROLOGIAL
- ○ Mental health concerns
- ○ Visual disturbance
- ○ Dizziness
- ○ Fainting
- ○ Seizures
- ○ Headaches
- ○ Numbness in arms / legs / hands / feet
- ○ Nerve pain
- ○ Poor coordination
- ○ Weakness

RESPIRATORY
- ○ Chronic cough
- ○ Spitting up phlegm / blood
- ○ Chest pain
- ○ Wheezing
- ○ Difficulty breathing
- ○ Asthma

GASTROINTESTINAL
- ○ Poor appetite
- ○ Digestive problems
- ○ Heartburn
- ○ Ulcers
- ○ Nausea
- ○ Vomiting
- ○ Constipation
- ○ Diarrhea
- ○ Blood in stool
- ○ Gallbladder / jaundice
- ○ Colitis / Crohn's / IBS

CARDIOVASCULAR
- ○ Rapid heart beat
- ○ Slow heart beat
- ○ High / low blood pressure
- ○ Chest pain (left side)
- ○ Palpitations
- ○ Heart murmur
- ○ Congenital heart defect
- ○ Hardening of arteries
- ○ Swollen ankles
- ○ Poor circulation
- ○ Cold hands or feet
- ○ Varicose veins
- ○ Heart surgery / Pacemaker

MUSCLE & JOINT
- ○ Neck pain
- ○ Low back pain
- ○ Arm pain
- ○ Shoulder pain
- ○ Hand pain
- ○ Leg pain
- ○ Knee pain
- ○ Foot pain
- ○ Pain between shoulders
- ○ Swollen joints
- ○ Spinal curvature (Scoliosis)
- ○ Arthritis
- ○ Fractures

EARS / EYES / NOSE / THROAT
- ○ Eye pain
- ○ Double vision
- ○ Ringing in ears
- ○ Deafness
- ○ Nosebleeds
- ○ Difficulty swallowing
- ○ Hoarseness
- ○ Thyroid problems
- ○ Sinus problems
- ○ Nasal drainage
- ○ Enlarged glands

GENITOURINARY
- ○ Frequent urination
- ○ Uncontrollable flow
- ○ Painful urination
- ○ Blood in urine
- ○ Cloudy urine
- ○ Kidney problems
- ○ Prostate concerns

DIAGNOSED CONDITIONS
- ○ Shingles
- ○ Rheumatic fever
- ○ Cancer / Chemotherapy
- ○ Hepatitis
- ○ Venereal disease
- ○ Tuberculosis
- ○ Diabetes (I / II)
- ○ Stroke
- ○ Epilepsy

FOR WOMEN ONLY
- ○ Painful menstruation
- ○ Irregular cycle
- ○ Cramps or back pain
- ○ Hot flashes
- ○ Menopausal symptoms
- ○ Birth control
- ○ Miscarriage
- ○ Difficulty conceiving

Health Habits

Do you smoke?	○ No	○ Yes	_____	Packs / Day
Do you drink alcohol?	○ No	○ Yes	_____	Drinks / Week
Do you drink coffee?	○ No	○ Yes	_____	Cups / Day
Do you spend time on the computer?	○ No	○ Yes	_____	Hours / Day
Is your computer station ergonomically correct?	○ No	○ Yes		
Do you exercise regularly?	○ No	○ Moderate	○ Daily	
Do you wear:	○ Heel lifts	○ Sole lifts	○ Insoles	○ Arch Supports
How old is your pillow?	○ Under 2 years	○ Over 2 years		
How old is your mattress?	○ Under 5 years	○ Over 5 years	○ Over 10 years	

Medications / Supplements You Now Take

Why this form is important...

Certain drugs can cause neuro-musculoskeletal symptoms, therefore it is important for our chiropractors to know what medications you are currently taking. The symptoms that you have presented to the clinic may be related to these medications. If you are unsure of the medication name and dosage it is imperative that you make note of it and let us know on your next visit. Likewise, certain nutritional supplements can alleviate neuro-musculoskeletal symptoms and it is just as important for our chiropractors to know too.

- ◯ Stimulants
- ◯ Blood Thinners
- ◯ Muscle Relaxers
- ◯ Blood Pressure Medicine
- ◯ Insulin
- ◯ Cholesterol Lowering Agents
- ◯ Pain Killers (including Aspirin)
- ◯ Birth Control
- ◯ Antidepressants
- ◯ Acid Reducers
- ◯ Other: _____

Please list any prescription, over-the-counter medications, or nutritional supplements you are currently taking:

Medication / Supplement	Dosage	Reason	Duration

Surgical History

Please list any surgeries you've had in the past: _____

Please list any upcoming surgeries: _____

Stress History

Name your biggest PHYSICAL stress: _____

Name your most significant CHEMICAL and/or NUTRITIONAL stress: _____

Name your largest source(s) of MENTAL and/or EMOTIONAL stress: _____

List any other sources of stress: _____

Family Health History

◯ Diabetes ◯ Depression ◯ Heart Disease ◯ Osteoporosis ◯ Digestive Issues / Irritable Bowel

◯ MS ◯ Stroke ◯ High Blood Pressure ◯ Arthritis ◯ Cancer ◯ Adverse Vaccine Reactions

◯ Other: _____

I hereby declare that the above statements are true and correct to the best of my knowledge.

_____ _____

Patient Signature Date (dd/mm/yyyy)

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 adjustments, 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 headaches, 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 care 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 affected area 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 or that 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 condtion.

  The consequences of a disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include inpaired 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 activites 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 traveling 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 progessing 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 with 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.

For Muscle Therapy, our clinic policy on **MISSED APPOINTMENTS** and **CANCELLATIONS without 24 hours notice** is as follows:
***First Time: No charge, just a warning. Second time and following: A missed appointment charge equivalent to the price of the appointment* Our massage appointment times are comprehensive (this means the time it takes you to change is included in the appointment).**

Please be involved in and responsible for your care. Inform your chiropractor immeditately of any changes in your condition.

DO NOT SIGN THIS FORM UNTIL YOU HAVE MET 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 the risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Patient Name (please print)

_____ _____
Signature of Patient Date

_____ _____
Signature of Chiropractor Date