Patient Health Record

Why This Form is Important

As a full spectrum Chiropractic office we focus on your ability 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. 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. If your complaint has resulted from a **work injury or motor vehicle accident**, please let our chiropractic assistants at the front desk know immediately.

About the Patient

Name: _____

Address: _____

_____

City: _____ Prov: _____ PC: _____

Birthdate: _____ yy/mm/dd Age: _____

◯ M ◯ F Number of Children: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Employer: _____

Martial status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Please provide your email address to recieve the following:

◯ Newsletters ◯ Reminders ◯ Birthday Present ◯ All

Email address: _____

(please print clearly)

Preferred method of contact:

◯ Home Phone ◯ Work Phone ◯ Cell Phone

◯ Email

◯ No phone calls

Who referred you to this office? _____

Were you aware that:	Yes	No
• Doctors of Chiropractic work with the nervous system?	◯	◯
• The nervous system controls all bodily functions and systems?	◯	◯
• Chiropractic is the largest natural healing profession in the world?	◯	◯
• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	◯	◯

Experience with Chiropractic

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before?

◯ Yes ◯ No

Reason for those visits? _____

_____

Doctor's name? _____

Approximate date of last visit? _____

Has any adult in your family seen a Chiropractor?

◯ Yes ◯ No

Has any child in your family seen a Chiropractor?

◯ Yes ◯ No

Reason For This Visit

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to:

◯ Job ◯ Sports ◯ Auto ◯ Fall ◯ Chronic Discomfort ◯ Home Injury ◯ Other

Please explain: _____

If job related, have you made a report of your accident to your employer? ◯ Yes ◯ No

When did this condition begin? _____

Has this condition:

◯ Gotten worse ◯ Gotten better ◯ Stayed constant ◯ Comes and goes

Does this condition interfere with:

◯ Work ◯ Sleep ◯ Daily routine ◯ Other

Please explain: _____

Have you seen anyone else for this condition?

◯ Yes ◯ No

Doctor's Name _____

Type of Treatment _____

Result _____

Medications I Now Take

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

Family Health History

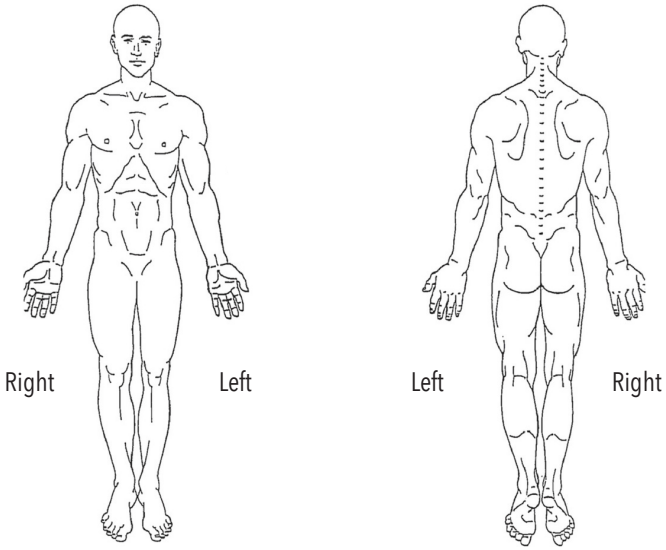
- ◯ Diabetes
- ◯ Cancer
- ◯ Stroke
- ◯ Heart Disease
- ◯ High Blood Pressure
- ◯ Arthritis
- ◯ Other: _____

Health Habits

Do you smoke?	◯ No	◯ Yes	_____ Packs / Day
Do you drink alcohol?	◯ No	◯ Yes	_____ Drinks / Day
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:	◯ Heal lifts	◯ Sole lifts	◯ Insoles ◯ Arch Supports
How old is your pillow?	_____		
How old is your mattress?	_____		

Type of Pain: ◯ Stiffness ◯ Burning ◯ Numb/Tingling ◯ Sharp ◯ Soreness/Achy

Mark the areas of pain on the figures below and then circle on the pain scale from 0-10 the pain you feel with this condition. 10 being the worst pain you have ever felt and 0 being no pain at all.



Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back Pain
0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain
0 1 2 3 4 5 6 7 8 9 10

Foot, Ankle Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain
_____

Health Conditions

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the visit, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ◯ Severe or Frequent Headaches
- ◯ Sinus problems
- ◯ Heart Murmur
- ◯ High / Low Blood Pressure
- ◯ Rheumatic fever
- ◯ Psychiatric problems
- ◯ Thyroid problems
- ◯ Lower back problems
- ◯ Congenital Heart Defect
- ◯ Heart Surgery / Pacemaker
- ◯ Hepatitis
- ◯ Cancer
- ◯ Chemotherapy
- ◯ Difficulty breathing
- ◯ Frequent neck pain
- ◯ Numbness or pain in arms / legs / hands
- ◯ Venereal Disease
- ◯ Ulcers / Colitis
- ◯ Tuberculosis
- ◯ Shingles
- ◯ Kidney problems
- ◯ Dizziness
- ◯ Loss of sleep
- ◯ Pain between shoulders
- ◯ Asthma
- ◯ Arthritis
- ◯ Alcohol / Drug Abuse
- ◯ Digestive Problems
- ◯ Diabetes

For Women:

	Yes	No
Are you pregnant?	◯	◯
Are you nursing?	◯	◯
Are you taking birth control?	◯	◯
Do you experience painful menstruation?	◯	◯
Do you have irregular cycles?	◯	◯

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.

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)	Alberta Health Care #
Signature of Patient	Date
Signature of Chiropractor	Date

CHIROPRACTIC
CENTER FOR HEALTH

PREGNANCY PROFILE & HISTORY FORM

Date: _____

Name: _____

Due Date: _____ **How many weeks?** _____

I plan to have my birth at _____

This is my (1st/2nd/3rd/etc) _____ **pregnancy**

I am under the care of the following healthcare providers (OBGYN/Midwife/Doula; Names?):

_____

Have there been any issues/concerns with any of your check-ups so far? If so, please explain.

_____

Please describe your pregnancy up to this point (eg. nausea, lightheadedness, fatigue, aches or pains, blood pressure, stress, anxiety, etc):

1st Trimester:

_____

_____

_____

2nd Trimester:

_____

_____

_____

3rd Trimester:

_____

_____

_____

Ultrasounds (#? when? purpose?)

_____

_____

At any time has baby been breech, oblique or transverse? If yes, when?

_____

Are you working? If yes, when do you plan to work until? What type of work?

_____

Please describe your previous birth experience (# of pregnancies, miscarriages, births, interventions, complications):

_____

_____

_____

Home / Hospital / Birthing Center

Vaginal / Scheduled C-section / Emergency C-section

Epidural / Induction / Episiotomy

Vacuum / Forceps / Manual Maneuver

Labour time: Total: _____ Active (5cm to delivery): _____

Baby weight _____

Length _____

Feeding: Breast? Pump? For how long? _____

No breast? No/low supply? Latch issues? Medical condition? By choice?

Do you have any specific concerns you would like us to address?

_____

_____

_____

Can we provide you with more information about (circle all that apply):

Chiropractic ● Acupuncture ● Massage ● Pelvic Floor Physiotherapy ● Nutrition

Naturopath Counselling ● Doula support ● Midwifery care ● Postpartum support

Lactation Consultants Birthing classes ● Yoga ● Other resources