HealthFirst CHIROPRACTIC & Wellness Centre

Information reviewed with patient Todays date _____

Dr. Initials_____

Name: L _____ F _____ Sex: Male ____Female _____

Address:_____

City: _____Postal Code:_____

Home Phone: # _____Work: # _____Cell: #_____

Email: _____ ☐ I do not want to be contacted via email

Height: _____ Weight:_____lbs. Date of Birth: _____Age: _____

Occupation: _____Employer_____

Spouse's Name: _____

Name of Children and Ages: _____

BC Health Care #: _____

Have you ever received Chiropractic care? Yes / No

If yes, who from and what for? _____ When:_____

How did you find out about our office? _____

If you were referred to our office, who may we thank? _____

Have you received spinal x-rays in the last 2 years? Yes / No

Do you wear orthotics or special shoe inserts? Yes / No (if yes, how old are they?) _____

If yes, Date:_____

Is this related to a Motor Vehicle Accident in the **last 10 days**? Yes / No. If yes is this an insurance claim? Yes / No

Is this a work-related injury (***WCB Claim***)? Yes / No

Is there a chance you could be **pregnant**? Yes / No

Existing Symptoms

If you have a chief complaint(s), please describe briefly: (include how and when problem started)

_____

_____

_____

CIRCLE ALL THAT APPLY

The problem occurred: Gradually Suddenly

Condition is worse with: Right rotation / Left rotation / forward bending / backward bending/ right bending/ left

Is the condition: Intermittent Constant

Is it worse in the: Am PM Same

Does it radiate? Yes / No If yes, where? _____

Is the pain getting progressively worse? Yes / No

Have you had this problem in the past? Yes / No

The condition interferes with my: Sleep Work Daily Routine Family Life Exercise Mood

What activities aggravate your pain/condition?

_____

What (if anything) relieves your pain/condition?

_____

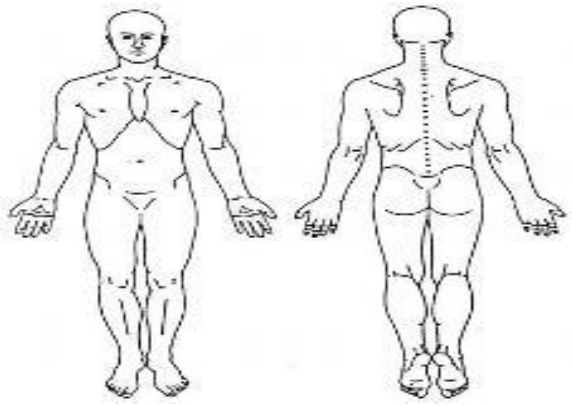
Have you received treatment for this issue? Yes / No If yes, what and did it help?

_____

Pain Diagram

Mark the areas on this body where you feel the described sensation. Use the appropriate symbols.

Aching (**), Burning (- -), Stabbing (//) Numbness (XX), Pins/Needles (++),



On a scale between 0 (no pain) and 10 (intense pain) Circle where you are currently at:

0----1----2----3----4----5----6----7----8----9----10

System Review

Please indicate by circling any of the following conditions you may be experiencing or have experienced in the past

Headaches	Shoulder pain	Constipation / Diarrhea
Migraines	Depression / anxiety	Low back pain
Neck pain	Upper back pain	Diabetes
Chronic fatigue	Chronic nausea	Blood pressure problems
Ringing in the ears	Mid back pain	Cancer
Dizziness	Heartburn	Foot pain
Ear infections	Digestive issues	Bladder problems
Sinus problems	Asthma	Sexual dysfunction
Swallowing difficulties	Difficulty breathing	Allergies
Vision changes	Chest pain	Osteoporosis
Sleeping problems	Heart irregularities	Arthritis
Wrist pain	stroke	Cramping in the legs
Carpal tunnel	Leg pain	Scoliosis
Arm pain	Knee pain	Degenerative disc

Is there family history of (circle): Heart Disease Stroke Cancer Diabetes Other

Please list any vitamins or medications you are currently on: _____

_____

_____

List any surgeries or hospitalizations you have had and include when: _____

_____

_____

Lifestyle Events and Habits

The 3 main stressors that may compromise your well-being:

Briefly describe any notable **injuries, head traumas, concussions, broken bones, slips or falls**

_____

_____

List any **motor vehicle accident** injuries: include date if known and describe collision (rear-end, rollover, etc.)

_____

_____

Circle what you spend most of your day doing:
Sitting / Bending Forward / Twisting / Lifting / Driving / Computer
If yes to sitting/driving/computer, how many hours per day do you spend at these activities? _____
Do you exercise on a regular basis? Yes / No
Do you sleep on your: Back / Side / Stomach

Rate your posture out of 10 (0 - poor 10 - excellent):

0----1----2----3----4----5----6----7----8----9----10

Rate the amount of physical stress that your body goes through on a daily basis:
(0 - no physical stress 5 - moderate physical stress 10—heavy stress load):

0----1----2----3----4----5----6----7----8----9----10

Chemical Stress

Do you smoke? Yes / No If yes, how much and how long? _____
Alcohol consumption: Yes / No If yes, how much? Rarely Weekly Daily
My caffeine intake is: Low Moderate High
I eat processed foods: Rarely Occasionally Often
I use over the counter drugs (Aspirin, etc.): Rarely Occasionally Often

Emotional Stress

My stresses include: Work Home School Finances Family
Relationships Health Problems Other? _____

Rate your stress level (0 - No stress 10 - Always stressed)

0----1----2----3----4----5----6----7----8----9----10

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

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 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