HANDLEY CHIROPRACTIC CLINIC
Dr. Leonard Handley, D.C.
484 Days Road | Kingston, ON K7M 5R4
(613) 384-1008 ● www.handleychiropractic.com

PATIENT ENTRANCE FORM

PATIENT INFORMATION:

Patient Name:..... Date:.....

Address: .....

City/Province: ..... Postal Code:.....

Tel# *(home):* ( ).....Tel# *(work):* ( ) ..... Email: .....

Date of Birth (dd/MMM/yy):..... Age:..... Marital Status *(please check)*: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse's Name: ..... No. of children:.....Names:.....

Closest Relative:..... Relation: ..... Tel#: ( ).....

Your Occupation: .....

Employer: .....

Address: .....

City/Province: ..... Tel#: ( ).....

Extended Health Care Company (insurance) :..... Policy #:.....

Insurance Credit Card No.:..... Exp: .....

How did you hear about our clinic? *(please check)*: ❑ website ❑ phonebook ❑ friend ❑ sign ❑ other .....

CLAIM WILL BE MADE AGAINST:

1) Recent motor vehicle accident ❑ YES ❑ NO *(If YES, see attached)*

2) Work related injury/accident ❑ YES ❑ NO *(If YES, see attached)*

PRIOR CHIROPRACTIC CARE:

Name:..... Tel#: ( ) .....

Were X-Rays taken? ❑ YES ❑ NO *If YES, date taken*: ..... Results *(pls check)*: ❑ excellent ❑ good ❑ fair ❑ poor

MEDICAL DOCTOR:

Doctor's Name: ..... Tel#: ( ) .....

Clinic:..... City.....

Date of Last Appointment: ..... Date of Last Physical .....

REASON FOR CONSULTING OUR CLINIC:

.....

.....

.....

Expectations: .....

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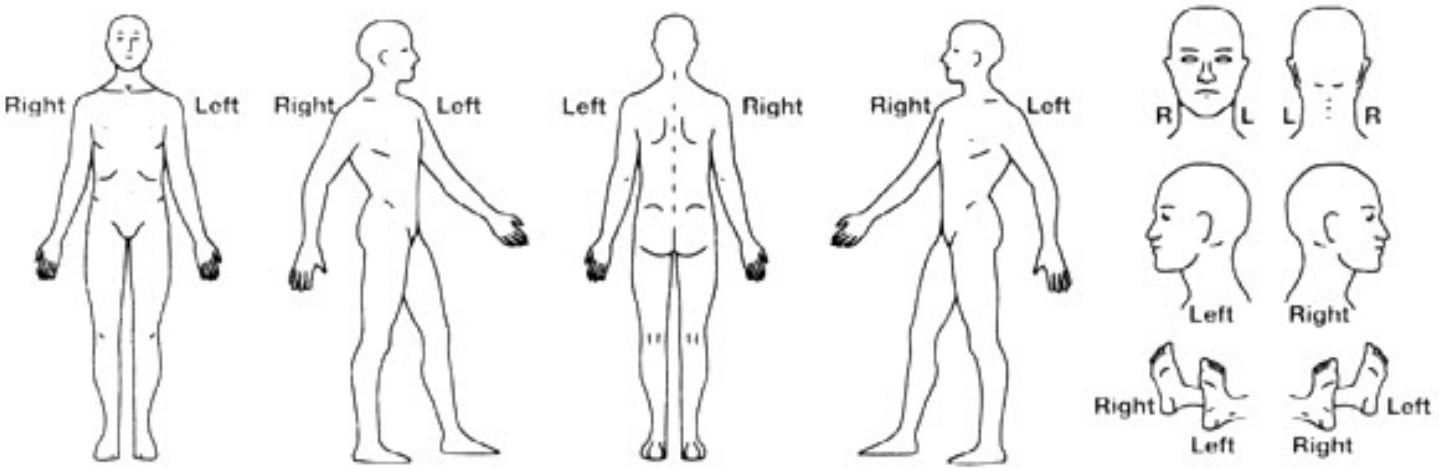
Please mark the areas on the appropriate diagram(s) below where you feel the described sensations, using the appropriate symbols.

Be sure to include ALL of your affected areas (even if they're not why you've come today!):

Numbness:	Pins & Needles:	Burning:	Aching:	Stabbing:
• • • • •	0 0 0 0 0	x x x x x	* * * * *	/ / / / /
• • • • •	0 0 0 0 0	x x x x x	* * * * *	/ / / / /
• • • • •	0 0 0 0 0	x x x x x	* * * * *	/ / / / /



Have you ever had any of the following? ***(please check)*****:**

❑ aneurysm ❑ stroke(s) ❑epilepsy ❑diabetes ❑arthritis ❑osteoporosis ❑cancer ❑polio ❑pleurisy

❑hepatitis ❑ "nerves" ❑fatigue ❑allergies ❑asthma ❑pneumonia ❑psoriasis ❑HIV ❑venereal disease

❑sleeping difficulty.....

❑heart conditions.....

❑sinus conditions.....

❑respiratory conditions.....

Childhood conditions experienced ***(please check)*****:**

❑measles ❑stroke(s) ❑chicken pox ❑whooping cough ❑scarlet fever ❑diphtheria ❑rheumatic fever

❑typhoid fever ❑ear infections ❑tubes in ears ❑chronic illness.....

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PAST MEDICAL HISTORY:

Please check the appropriate box for any of the following symptoms that you currently have or have previously had.

O = Occasional **F** = Frequent **C** = Constant

O F C

GENERAL

- ❑ ❑ ❑ allergy
- ❑ ❑ ❑ chills
- ❑ ❑ ❑ convulsions
- ❑ ❑ ❑ dizziness
- ❑ ❑ ❑ fainting
- ❑ ❑ ❑ fevers
- ❑ ❑ ❑ headaches
- ❑ ❑ ❑ loss of sleep
- ❑ ❑ ❑ nervousness
- ❑ ❑ ❑ depression
- ❑ ❑ ❑ neuralgia
- ❑ ❑ ❑ numbness
- ❑ ❑ ❑ sweats
- ❑ ❑ ❑ loss of weight
- ❑ ❑ ❑ tremors

MUSCLE & JOINT

- ❑ ❑ ❑ arthritis
- ❑ ❑ ❑ bursitis
- ❑ ❑ ❑ foot trouble
- ❑ ❑ ❑ hernia
- ❑ ❑ ❑ low back pain
- ❑ ❑ ❑ neck pain
- ❑ ❑ ❑ neck stiffness
- ❑ ❑ ❑ pain between shoulders

RESPIRATORY

- ❑ ❑ ❑ chest pain
- ❑ ❑ ❑ chronic cough
- ❑ ❑ ❑ difficulty breathing
- ❑ ❑ ❑ spitting blood
- ❑ ❑ ❑ throat phlegm
- ❑ ❑ ❑ wheezing

EYES/EARS/NOSE/THROAT

- ❑ ❑ ❑ colds
- ❑ ❑ ❑ crossed eyes
- ❑ ❑ ❑ deafness
- ❑ ❑ ❑ dental decay
- ❑ ❑ ❑ asthma
- ❑ ❑ ❑ ear aches
- ❑ ❑ ❑ ear discharges
- ❑ ❑ ❑ ear noises

O F C

EYES/EARS/NOSE/THROAT, continued

- ❑ ❑ ❑ sinus infections
- ❑ ❑ ❑ enlarged glands
- ❑ ❑ ❑ enlarged thyroid
- ❑ ❑ ❑ sore throats
- ❑ ❑ ❑ tonsillitis
- ❑ ❑ ❑ eye pain
- ❑ ❑ ❑ failing vision
- ❑ ❑ ❑ far sighted
- ❑ ❑ ❑ gum trouble
- ❑ ❑ ❑ hay fever
- ❑ ❑ ❑ hoarseness
- ❑ ❑ ❑ nasal obstruction
- ❑ ❑ ❑ near sighted
- ❑ ❑ ❑ nosebleeds

CARDIOVASCULAR

- ❑ ❑ ❑ vomiting
- ❑ ❑ ❑ vomiting blood
- ❑ ❑ ❑ rapid heart beat
- ❑ ❑ ❑ slow heart beat
- ❑ ❑ ❑ swelling of ankles
- ❑ ❑ ❑ hardening of arteries
- ❑ ❑ ❑ high blood pressure
- ❑ ❑ ❑ low blood pressure
- ❑ ❑ ❑ pain over heart
- ❑ ❑ ❑ poor circulation
- ❑ ❑ ❑ pain over heart

GASTROINTENSTINAL

- ❑ ❑ ❑ excess hunger
- ❑ ❑ ❑ burping or gas
- ❑ ❑ ❑ liver trouble
- ❑ ❑ ❑ colitis
- ❑ ❑ ❑ colon trouble
- ❑ ❑ ❑ constipation
- ❑ ❑ ❑ diarrhea
- ❑ ❑ ❑ distension of abdomen
- ❑ ❑ ❑ stomach pain
- ❑ ❑ ❑ gall bladder trouble
- ❑ ❑ ❑ hemorrhoids
- ❑ ❑ ❑ intestinal worms
- ❑ ❑ ❑ jaundice
- ❑ ❑ ❑ poor appetite

O F C

SKIN

- ❑ ❑ ❑ boils
- ❑ ❑ ❑ bruise easily
- ❑ ❑ ❑ hives/allergies
- ❑ ❑ ❑ itching
- ❑ ❑ ❑ skin rash
- ❑ ❑ ❑ varicose veins

GASTROINTENSTINAL

- ❑ ❑ ❑ bed wetting
- ❑ ❑ ❑ blood in urine
- ❑ ❑ ❑ frequent urination
- ❑ ❑ ❑ loss of urine control
- ❑ ❑ ❑ kidney infection
- ❑ ❑ ❑ painful urination
- ❑ ❑ ❑ prostate trouble
- ❑ ❑ ❑ pus in urine
- ❑ ❑ ❑ smell of urine

PAIN/NUMBNESS IN

- ❑ ❑ ❑ shoulders
- ❑ ❑ ❑ arms
- ❑ ❑ ❑ hands
- ❑ ❑ ❑ hips
- ❑ ❑ ❑ legs
- ❑ ❑ ❑ knees
- ❑ ❑ ❑ ankles
- ❑ ❑ ❑ feet
- ❑ ❑ ❑ tail bone
- ❑ ❑ ❑ sciatica
- ❑ ❑ ❑ swollen joints

FOR WOMEN ONLY

- ❑ ❑ ❑ cramps
- ❑ ❑ ❑ heavy flow
- ❑ ❑ ❑ light flow
- ❑ ❑ ❑ irregular cycle
- ❑ ❑ ❑ painful cycle
- ❑ ❑ ❑ discharge
- ❑ ❑ ❑ sore breasts

Menopausal: ❑ YES ❑ NO

Last menstruation: .....

Pregnant: ❑YES ❑ NO

Date Due: .....

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PAST MEDICAL HISTORY, *continued*

*1 unit = 1 glass of wine
1 bottle of beer
1 shot of liquor

HABITS OF LIFESTYLE:

Do you smoke? ❑YES ❑NO .....packs/week Do you consume alcohol? ❑YES ❑ NO ..... units*/week

Do you exercise? ❑YES ❑NO .....times/week Activities.....

Rate your sleep in hours per night: ❑<4 ❑ 4-6 ❑ 6-8 ❑8-10 ❑10-12 ❑ >12 Do you wake rested?: ❑ YES ❑ NO

Rate your appetite: ❑ Poor ❑Fair ❑Medium ❑Good ❑Excellent

Rate your diet: ❑Poor ❑Fair ❑Medium ❑Good ❑Excellent

Meals you eat regularly: ❑Breakfast ❑Lunch ❑Dinner

Meals you eat per day: ❑none ❑1 meal ❑2 meals ❑3 meals ❑4 meals ❑more than 4 meals

Date of last dental examination: .....

List all falls and/or accidents: .....

.....

.....

List all surgeries and/or operations:.....

.....

.....

List surgeries that have been recommended, but not yet performed: .....

.....

.....

Have you ever been knocked unconscious? ❑YES ❑NO ❑UNSURE *If YES, for how long?*:.....

Have you previously been hospitalized? ❑YES ❑NO For what?:.....

.....

List any medications and/or drugs you are currently taking: .....

.....

.....

Do you take vitamins and/or minerals?: ❑YES ❑NO List types: .....

.....

.....

Are there any family health conditions and/or problems that we should be aware of?: ❑ YES ❑ NO ❑UNSURE If YES, please list:

.....

.....

.....

.....

.....

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read the following carefully and be sure to sign this document.

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience rib fractures or muscle and ligament strains or sprains following spinal adjustments.

b) There are reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and may, on rare occasion, result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.

c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies that have been conducted over many years, and has been demonstrated to be effective treatment for spinal pain headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

I acknowledge that I have discussed, or have had the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this.....day of ..... ,20..... .
date *month* *year*

....
Name of Patient (or Parent/Guardian) **PLEASE PRINT CLEARLY** Signature of Patient (or Parent/Guardian)

Dr. Leonard Handley, D.C. .....
Name Of Witness Signature of Witness