Confidential Patient Health Record

Patient information

Date: _____/_____/_____

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: Home _____ Work _____

Cell: _____ Email: _____

Date of birth (dd/mm/yy) _____/_____/_____ Age: _____ Marital Status: S M C D W

Number of children: _____ Age of children: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship to contact: _____

Name of Medical Doctor: _____

Address: _____ May we contact your doctor? Y / N

Date of last visit to your medical doctor: ____/____/____ Date of last dental exam: ___/____/_____

Have you ever been to a chiropractor before? Y / N Where?_____

For what condition?_____ Results?_____

Last appointment _____ Reason for leaving?_____

Are you coming here regarding an injury from a recent motor vehicle accident? Y / N or a workplace accident/injury? Y / N. If yes , Date:_____

How did you hear about the clinic? Internet___ Ad__ Doctor ___ Other ___ Friend(name) _____

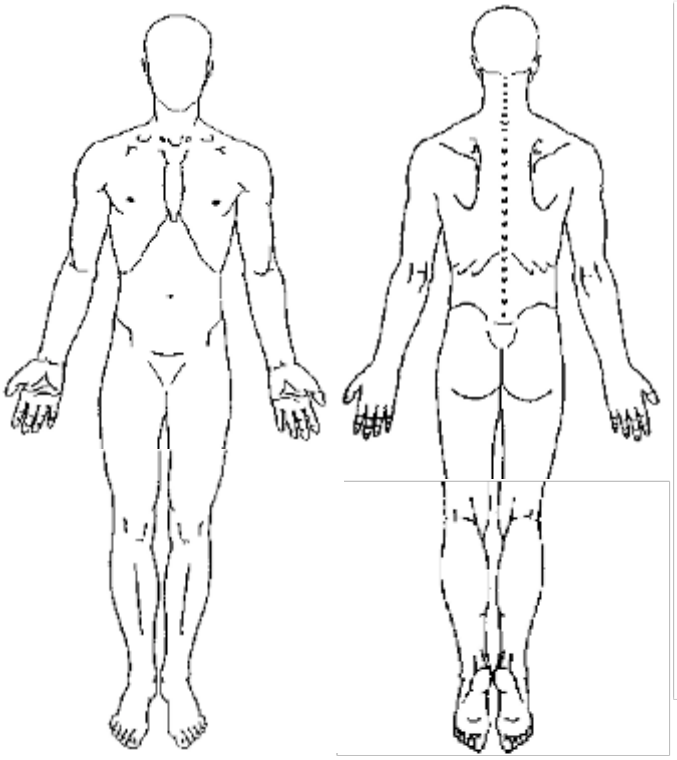
Personal information collected, used, stored and disclosed by this medical practice is confidential information.
24hrs notice is required to cancel or change appointments otherwise full charges apply.

Patient Name: _____ Date: _____

Current health condition

Purpose of this appointment: _____
_____

What is your goal in coming to this clinic? _____
_____



Draw in your face.

Mark the areas on the bodies where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness:	●●●● ●●●●
Pins and Needles:	0000 0000
Burning:	XXXX XXXX
Aching:	vvvvvv vvvvvv
Sharp/Stabbing:	/ / / / / / / / / / / /
Stiffness:	##### #####

Doctors only

Init: _____

On a scale of 0 to 10 (10 being the worst pain that you have ever felt), how would You rate your pain: At best: ____At worst: ____Usual:_____

When did this condition begin? _____
Anything associated with the onset? _____
_____

What increases the pain?

_____
_____
_____

What decreases the pain?

_____
_____
_____

Previous treatment for these complaints? _____
_____

Since it started, is your condition the **Same / Better / Worse**? Please circle.
Do you have any other problems with bones / joints / muscles?
Please describe _____
_____
_____

Patient Name: _____ Date:_____

Past Health history

Medical problems / hospitalizations / treatment:_____

Previous surgeries:_____

Surgeries recommended but not performed:_____

Current medications / vitamins:_____

Allergies to drugs / medications:_____

Any previous fractures? _____

Do you suffer from frequent or intense headaches? Y / N

Do you have a history of unexplained weight loss or weight gain? Y / N

Have you been diagnosed with any of the following (please circle all that apply):

IBS Chron's Psoriatic arthritis Rheumatoid arthritis Osteoarthritis Fibromyalgia
High Cholesterol High Blood pressure Heart Attack Angina Heart Surgery Diabetes
Stroke Deep vein thrombosis Blood Clotting Disorder TIA Cancer Gout

Lifestyle Habits

Do you smoke? Y/ N How many per day? _____ #of years _____ Have you ever smoked? Y / N
If yes, when did you quit? _____ How much did you smoke? _____ # of years _____

Do you consume alcohol? Y / N How many drinks per week?_____

Do you drink coffee? Y / N #cups per day? _____ Do you drink pop/soda? Y / N # per day _____

Rate your diet: Poor Fair Medium Good Excellent

Any trouble sleeping? Y / N If yes, reason _____

Do you exercise regularly? Y / N Types of exercise frequently performed:

_____

Health and wellness screening questionnaire

Do you have any skin problems? Describe._____

Do you have any nerve/psychiatric/psychological problems? Describe.

_____

Do you have any problems with your eyes/ears/nose/throat? Describe.

_____

Do you have any respiratory problems (asthma, bronchitis)? Describe.

_____

Do you have any digestive problems (ulcer, irritable bowel, indigestion, constipation, hiatus hernia)? Describe._____

Do you have any urinary system problems (recurrent infection, prostate, kidney problems)? Describe. _____

Questions for women only

Has your doctor ever indicated that you have osteoporosis? Y / N Does it run in your family? Y/ N

Have you had a bone density test in the past two years? Y / N . If yes, results?_____

Are you pregnant or planning pregnancy? Y / N

Do you have any problems with your breasts, menstrual cycle, Menopause? Y / N
if yes, please describe _____

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