



Chiropractic Intake Form

Welcome to our clinic. Please complete the following questionnaire. Your answers will help determine if chiropractic care can help you. If we do not believe your condition will respond satisfactorily, we will refer you to the appropriate health-care provider in a timely manner

Date _____

PERSONAL INFORMATION

Name _____ / _____ / _____
last first middle initial

Personal Health # _____ - _____ Male Female

Home Address _____ City _____

Postal Code _____ Email Address _____

Phone #'s: Home _____ Cell _____ Bus _____

Birth Date ____ / ____ / ____ Height: _____ Weight: _____ Marital Status M S W D
Y M D

Current Occupation: _____

Family Doctor (G.P.) _____
Name Location Phone Number

Please be advised that in the interest of inter-professional communication, we will be in touch with your physician regarding the care you receive at our clinic.

Emergency Contact _____
Name Phone Number Relationship

Whom can we thank for your referral? We would like to send them a token of our appreciation. _____

Is this a workplace injury? Yes No *Please be advised that we do not accept WCB cases.

Is your injury the result of a motor vehicle accident? Yes No If yes, additional intake forms are required.

The healthcare team in this clinic meets regularly to discuss interdisciplinary co-treatment of our patients. If you **do not** wish us to discuss your case, please initial here: _____

Our clinic is committed to evidence-based practice and contributing to the scientific research community. All patient information used in research is kept strictly confidential and is used only with permission of the patient. Do you consent to allow your information to be used in future research? Yes No

Missed office Visits:

A charge of \$62 will be made in the event of a missed office visit, or if less than 24 hours' notice is given when canceling an appointment.

Re-examinations:

Re-examinations are done in the event of a six month time lapse between office visits

HEALTH INFORMATION

1. Have you had any previous chiropractic care?

- Yes, reason? _____
- No If yes; reason? _____

2. In your own words, please describe your chief complaint and when you first noticed the problem

3. What seems to make the problem better? _____

4. What seems to make the problem worse? _____

5. What type of pain is it? (Please check)

- Sharp
- Stabbing
- Achy
- Burning
- Dull
- Diffuse
- Localized

6. Does the pain radiate? Yes No

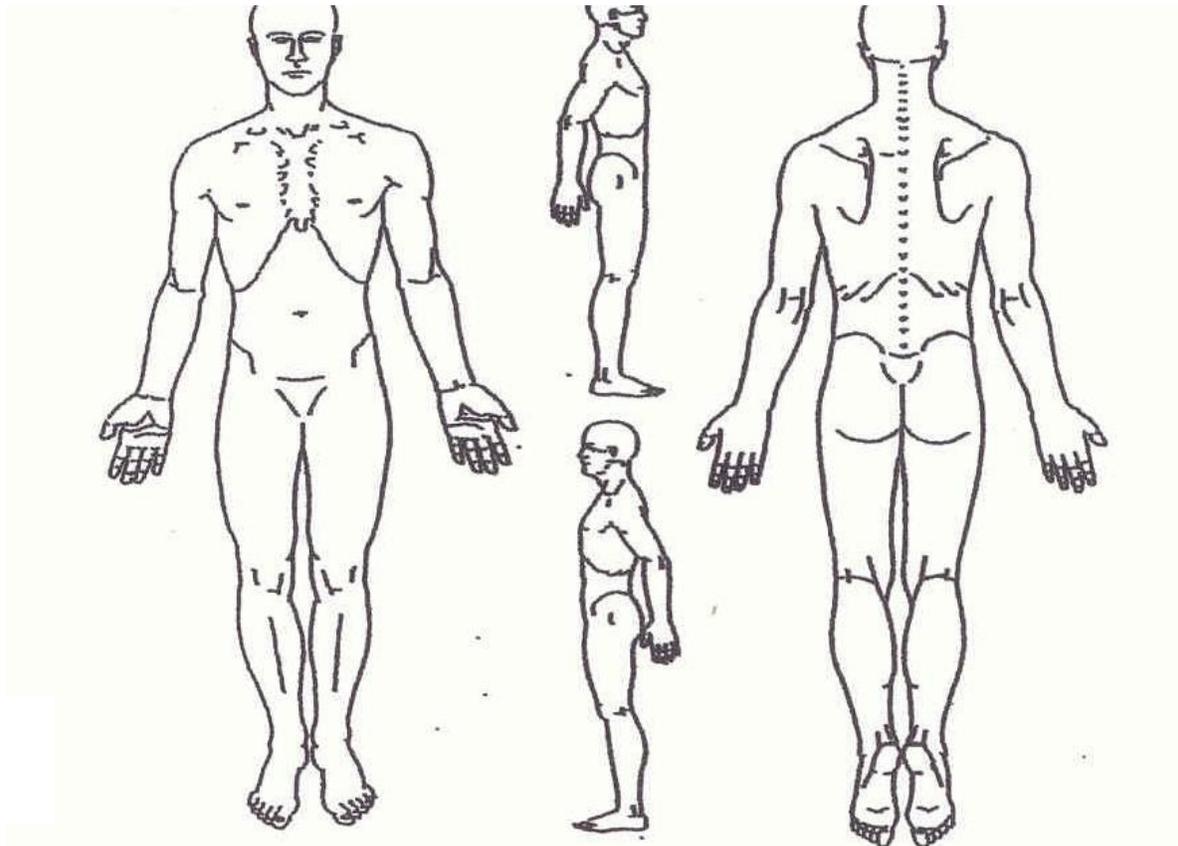
7. At what time of day does your pain seem to be at its worst? _____

8. Has this problem been treated before?

- Yes, how? _____
- No

9. Mark the areas on the body drawings where you feel the following sensations using their corresponding symbols. Include all affected areas

Sensation:	Ache	Numbness	Pins and Needles	Burning	Stabbing
		+++++	ooooo	bbbbb	sssss
		+++++	ooooo	bbbbb	sssss



10. Using the line scale provided below rate the pain you are experiencing **now**

No 0=====1=====2=====3=====4=====5=====6=====7=====8=====9=====10 Severe
Pain Pain

PHYSICAL HISTORY

Please mark a **1** beside any conditions you have had in the **past**

Please mark a **2** beside any condition that you have **presently**

<p>Musculoskeletal system</p> <p><input type="checkbox"/> Neck problems</p> <p><input type="checkbox"/> Upper back problems</p> <p><input type="checkbox"/> Shoulder problems</p> <p><input type="checkbox"/> Elbow/wrist problems</p> <p><input type="checkbox"/> Low back problems</p> <p><input type="checkbox"/> Knee problems</p> <p><input type="checkbox"/> Ankle/foot</p> <p><input type="checkbox"/> Arthritis</p>	<p>Nervous system</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Loss of feeling</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Confusion</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Forgetfulness</p>	<p>Cardio-Vascular-Resp.</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Difficult breathing</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Coughing phlegm/blood</p> <p><input type="checkbox"/> Lung problems</p> <p><input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Hypoglycemia</p>
<p>Genito-Urinary system</p> <p><input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Excessive urine</p> <p><input type="checkbox"/> Scanty urine</p> <p><input type="checkbox"/> Discolored urine</p>	<p>Gastrointestinal system</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Nausea/vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Bloody/black stool</p> <p><input type="checkbox"/> Liver/gallbladder trouble</p> <p><input type="checkbox"/> Weight trouble</p>	<p>Ear, Eyes, Nose, Throat</p> <p><input type="checkbox"/> Eye problems</p> <p><input type="checkbox"/> Vision problems</p> <p><input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> Ear pain</p> <p><input type="checkbox"/> Ear ringing</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Hoarseness</p>
<p>Female</p> <p><input type="checkbox"/> Premenstrual syndrome</p> <p><input type="checkbox"/> Abnormal vaginal discharge</p> <p><input type="checkbox"/> Abnormal vaginal bleeding</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Breast pain, and/or lumps</p>		

Your first visit to the office includes both an initial consultation as well as an office visit. At the discretion of the doctor, your first visit may not consist of actual treatment.

Attire/Hygiene

Some treatments necessitate direct skin contact. Please bring shorts and / or a tank-top style shirt to each appointment and bathe before attending your appointment.

Please refrain from wearing any cologne, perfumes or scented lotions while in the clinic.

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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

Date _____ 20____