



New/Returning Patient Form

Patient Information

Today's Date: _____ Gender: Male Female Other: _____

Full LEGAL Name: _____ **Preferred Name:** _____

Address: _____ City: _____ Prov: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ **MSP # (Required):** _____

Age: _____ Birthdate: (DD)____ / (MM)____ / (YY)____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone No: _____

Is this a WCB injury: No Yes Are your injuries related to a Motor Vehicle Accident? No Yes

If yes, when did the accident occur? _____

Medical Information

Family Medical Doctor's Name: _____ Clinic: _____

Date of Last MD Visit: _____ Reason: _____

What therapy have you previously received? Chiropractic Massage Acupuncture Physiotherapy

How Did You Find Us?

Referred by Friend/Family Referred by Medical Doctor Internet/Website

Walk By Other: _____ Whom may we thank for this referral? _____

What is the Purpose of Your Visit?

What is your main health concern or complaint? _____

When and how did your symptoms first begin? _____

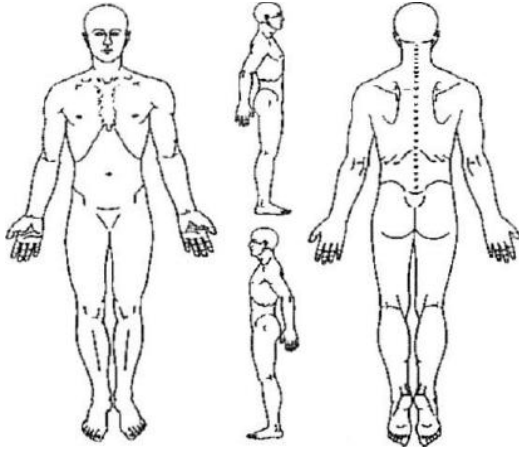
- Have you had this before? No Yes; Who did you see for treatment? _____
- Is it getting: Worse Better Not Changing

What do you hope to gain from your treatment here?

- Resolve Pain:** Get me moving pain-free
- Optimize Recovery:** Get me moving pain-free and provide guidance and rehabilitation to restore normal function
- Improve Overall Health:** Get me moving pain-free, provide guidance and rehabilitation to restore normal function and help me be proactive in my health and wellness.

What Are Your Symptoms?

On the diagram(s) below, please circle the area(s) that applies most to where you experience symptoms or feel pain.



Use these letters to describe the pain:

- S** sharp **D** dull **A** achy **H** hot **C** cold
- N** numb/tingling **DB** deep and boring
- V** variable

Please rate your pain from **0-10** (0 is LEAST and 10 is WORST): _____

When do you feel the pain? Constantly Intermittently At Night In the Morning

Does the pain radiate down your legs or arms? No Yes

What activities are you having problems with?

- Balance Gripping Lifting Reaching Standing Bending Housework Pulling Sitting Travelling
- Fatigue Kneeling Pushing Sleeping Walking Other _____

What relieves your pain?

- Rest Ice Massage Other: _____
- Movement Heat Medication: _____

Have you seen anyone else for this condition? No Yes: Who have you seen? _____

Have you had any imaging for this condition? X-Ray CT MRI Ultrasound Date: _____

Does this problem interfere with: Work Family & Social Life Sports & Hobbies Sleep

Do you have any secondary complaints? _____

Notes:

Family History

Is There a family history of:

	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
Mother's Side:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father's Side:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Health History

Please list any serious illnesses, injuries or surgeries and when they occurred: _____

Please list any medication you have taken in the past 6 months: _____

Please list any allergies: _____

Do you have: High blood pressure: No Yes High cholesterol: No Yes

Current weight (LBS): _____ Weight 1 year ago: _____

Review of Systems

Please check the box for any conditions or symptoms that you have had in the **past six months**

General

- Fainting
- Headaches
- Fever
- Excessive Sweating
- Loss of Weight
- Night Pain
- Loss of Sleep
- Anxiety / Nervousness

Neurological

- Dizziness
- Blurred Vision
- Paralysis
- Numbness / Tingling
- Nausea
- Convulsions
- Loss of Balance

Genitourinary

- Trouble Urinating
- Blood in Urine / Stool
- Kidney Infection
- Prostate Trouble
- Painful Menstruation
- Irregular / Absent Cycle
- Painful Breasts / Chest
- Menopause

Gastrointestinal

- Poor / Excessive Appetite
- Belching / Gas
- Vomiting
- IBS
- Constipation
- Diarrhea
- Crohn's
- Heartburn

Cardiovascular

- Chest Pain
- Previous Heart Attack
- Previous Stroke
- Angina
- Ankle Swelling
- Poor Circulation
- Irregular Heart Beat
- Varicose Veins

Respiratory

- Asthma
- Chronic Cough
- Difficulty Breathing
- Sinus Infections
- Spitting up Blood
- Spitting up Phlegm
- Sore Throat
- Frequent Colds

Muscle & Joint

- Low Back Pain
- Mid Back Pain
- Neck Pain
- Shoulder / Arm Pain
- Elbow Pain
- Knee / Leg Pain
- Hip / Groin Pain
- Wrist / Hand Pain
- Ankle / Foot Pain
- TMJ / Jaw Pain
- Fibromyalgia
- Arthritis
- Disc Herniation
- Sciatica
- Gout

Eyes / Ears / Nose / Throat

- Earaches / Infection
- Ringing in Ears
- Hearing Difficulty
- Eye Pain
- Worsening Vision



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 on occasion.

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)

Signature of Patient or Legal Guardian

Signature of Chiropractor

Date: _____, 20____

Date: _____, 20____