The Centre for Chiropractic Health

PATIENT ENTRANCE FORM

Date _____ Circle: Male Female

Name _____ Birth Date (dd/mm/yy) _____ Age _____

Address _____ Apt # _____ City _____ Province _____

Postal Code _____ Home # _____ Cell # _____

Work # _____ E-MAIL _____

Occupation _____ Employer _____

Name of Emergency Contact _____ Contact # _____

How were you referred to our office ? (include NAME) _____

Family Dr and # _____ Last physical exam date _____

Surgeries or illnesses (include dates) _____

Fractures or past injuries (includes dates) _____

Medications _____

X-RAYS taken: Yes No Date _____ Results _____

Have you been treated for any health condition by a physician/chiropractor in the last year? Yes No

If yes, describe _____

Extended Health Care Company _____

Do you need any help retaining information about your health insurance coverage? Yes No

AUTHORIZATION AND RELEASE

I authorize the doctor to release all information necessary to communicate with personal healthcare providers.

PAYMENT POLICY

I understand that payment is due at the time professional services are rendered to me. I understand that I am responsible for all costs of treatment care, regardless of insurance coverage.

MISSED APPOINTMENT POLICY

There is a $10 fee for missed appointments without any notification. Our office does not charge for cancelled appointments, but requests **12 hours notice** to reschedule an appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

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Name: _____

HEALTH HISTORY

Please indicate whether you have experienced any of the following relating to your current condition:

Fever / Chills	_____	Allergies	_____	Shoulder/Elbow/Hand Pain	____
Headaches	_____	Arthritis	_____	Hip/Knee/Foot Pain	____
Migraines	_____	Loss of Balance	_____	Numbness in Fingers	____
Stiff Neck	_____	Loss of Taste	_____	Numbness in Toes	____
Neck Pain	_____	Loss of Smell	_____	Shortness of Breath	____
Back Pain	_____	Difficulty Urinating	_____	Chest Pain / Tightness	____
Tension	_____	Unusual Bowel Patterns	_____	High Blood Pressure	____
Nervousness	_____	Hands Cold	_____	Indigestion Problems	____
Irritability	_____	Feet Cold	_____	Weight Loss / Gain	____
Dizziness	_____	Sinus Problems	_____	Diabetes	____
Fainting	_____	Ringing in Ears	_____	Joint Pain / Swelling	____
Weakness	_____	Depression	_____	Fatigue	____
Muscle Spasms	_____	Sleeping Problems	_____	Loss of Memory	____

Women: Menstrual Difficulties _____

Are you pregnant? _____

Date of Last Period _____

Date of Last Pap _____

Date of Last Mammogram _____

SOCIAL HISTORY

Please indicate whether you engage in these: **OFTEN = √** **SOMETIMES = S** **NEVER = X**

_____ Caffeine Intake
_____ Tobacco Use
_____ Alcohol Use
_____ Drug Use
_____ Exercise

_____ Social Pressures
_____ Financial Pressures
_____ High Stress Activity
_____ Other (please specify)
_____

FAMILY HISTORY

Please indicate diseases and conditions that are current health problems of a family member.

Condition _____ Family Member _____ Age _____

Condition _____ Family Member _____ Age _____

Condition _____ Family Member _____ Age _____

The Centre for Chiropractic Health

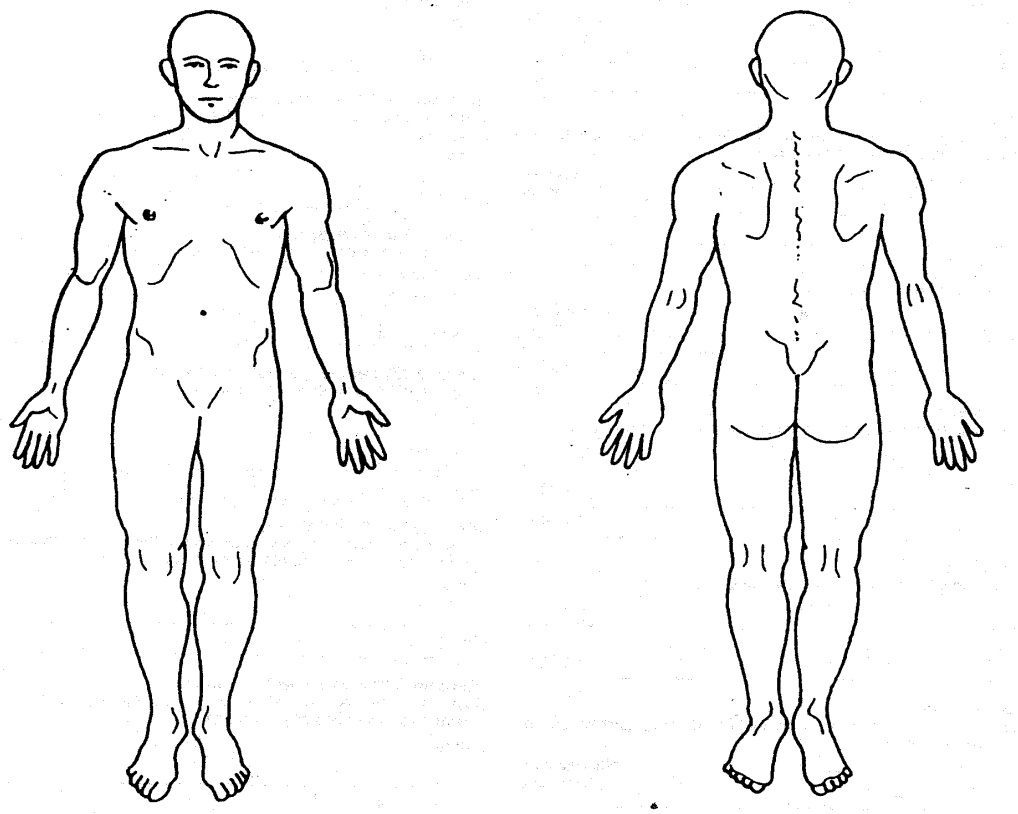
Name: _____

PAIN DRAWING & SCALE

TELL US WHERE YOU HURT

Mark the areas on your body where you feel your pain. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > >	Numbness = = = = =	Pins & Needles o o o o o
Burning x x x x x	Stabbing / / / / / / / /	Throbbing ~ ~ ~ ~ ~ ~ ~ ~



TELL US HOW MUCH YOU HURT

On a scale of 0 to 10, please mark with an "X" the level of your pain today. 0 indicates no pain while 10 indicates the worst pain you have ever experienced.

0 1 2 3 4 5 6 7 8 9 10

_____

The Centre for Chiropractic Health

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.

CONSENT TO CHIROPRACTIC TREATMENT

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.

Acupuncture

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, and stuck or bent needles.

I have been advised that only sterilized needles will be used. All acupuncture needles are properly disposed of after each and every 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.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

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

I consent to the chiropractic &/or acupuncture treatments offered or recommended to me by my chiropractor (including spinal adjustment).

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