Welcome to Our Chiropractic Office

Outline of Procedures for Our New Patients:

Step 1

All of our new patients are requested to complete this confidential **"Patient Health Record"**.

Step 2

Your first **"Consultation"** with the doctor to discuss your health problems.

Step 3

You will receive a **"Chiropractic Evaluation"** from the doctor to determine if chiropractic care is appropriate for your condition.

Step 4

We will perform an in-depth examination to determine weight distribution, asymmetries indicative of spinal abnormalities, and orthopedic and chiropractic studies and the effects posture may contribute to your current problem. In addition, if indicated, **x-rays** will be obtained to better visualize spinal problems.

Step 5

If your case requires immediate attention, **first day Chiropractic procedures** will be administered. (we always attempt to provide treatment during the initial visit)

Step 6

You will be advised as to a time you can return for a **"Report of Findings"** with the doctor. Together, we will discuss your examination results and whether or not, your case should be accepted. If accepted your recommended treatment program will be explained to you.

Our records show that those patients who respond most rapidly to care are those who have learned to help themselves. We give you, your family and friends the opportunity to learn what you can do to help us return you to health more quickly and cost effectively, and what one needs to do to stay healthy.

Step 7

Chiropractic care will begin and continue as scheduled until your condition has been fully corrected, or until the **maximum possible improvement has been obtained.**

To save time and allow us to better serve you, please complete all questions on the next pages. Thank you!

Personal History

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Birthdate: _____ Age: _____ Sex: ____M ☐ F ☐

Home Phone: _____ Cell Phone: _____

Email for our monthly practice newsletter: (not mandatory)_____

Business/Employer: _____ Business Phone: _____

Type of Work: _____

Circle One: Married Single Widowed Divorced Separated Other Number of Children: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Whom may we thank for referring you to this office? _____

How will you be paying your account? ☐ Visa ☐ MasterCard ☐ Cash ☐ Check ☐ AmEx ☐ Other

Current Health Condition

Current Complaint(s): _____

Other doctors seen for this condition? ☐ Yes ☐ No Who?_____

Type of Treatment: _____ Results: _____

When did this condition begin?_____ Has the condition occurred before? ☐ Yes ☐ No

Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other:_____

Date of Accident:_____ Time of Accident: _____

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Dow ☐ Cold ☐ Dampness ☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other:_____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent

Please describe how it feels when this problem is at its worse: _____

Place an X on the grade to indicate the severity of your pain: _____

LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:

Your ability to work? _____

Your ability to enjoy your family or your social time? _____

Your ability to enjoy your hobbies or sports? _____

At its worst, how old does this problem make you feel? _____

If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No

Drugs you take now: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Other:_____

Do you suffer from any other condition than the one you are now consulting us for?_____

_____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____

Have you had X-rays taken in the last six months? ☐ Yes ☐ No If yes, where? _____

Past Health History

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other: _____

Previous: Childhood Traumas ☐ _____ Sports Injuries ☐ _____
Motor Vehicle Accidents ☐ _____ Work Injurie ☐ _____ page 2

Hospitalization (other than above): _____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name: _____

Approximate Date of Last Visit: _____

Family Health History

Name of Family Physician: _____

Please indicate any health issues that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? _____

Have your children ever had a spinal check-up? ☐ No ☐ Yes ☐ If yes, where and when? _____

_____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.
Check any of the following you have had in the past six months:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Gas/Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black/Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

Male / Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

Females Only

When was your last period?

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

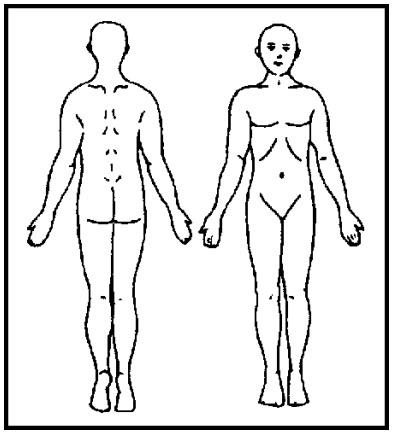
- ☐ Yes
- ☐ No

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little

Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema



Please outline on the diagram the area of your discomfort and any radiation of pain.

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐ Preventative Care – Life Enhancement and Wellness Care
- ☐ Corrective Care – Removing Cause and Remodeling Soft Tissue
- ☐ Relief Care – Band-Aid Care Only
- ☐ Check here if you want the doctor to select the type of care appropriate for your condition.

Please Read Carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and / or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic / staff member and / or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, rib fractures, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure that the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

_____ _____

Patient Signature Date