OCSI
Ottawa Chiropractic and Sports Injury Clinic

Confidential Patient Health Record

Patient Information Date: ____/____/____

Name: ______________________________________

Address:____

City: __________________ Province: __________ Postal Code: ___________

Telephone #: (Home) (____)______ - ________ Work: (____) ______ - ________

(Cell) (____)_______________ e-mail ___________________________

Employer: _________________________ Occupation: _____________________

Address: ____

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

Spouse's name ________________________ Number of children __________

Name of emergency contact: ____

Telephone number: (____) _________________

Relationship: _____________________________

How did you hear about this clinic? Phone book _ Advertisement _ Friend _____________

Are you coming here regarding injuries from a:

Recent motor vehicle accident? _ Yes, Date: _________________ _No

Work related accident / injury? _ Yes, Date: _________________ _ No

Have you made a report of your accident to your employer? Y / N

Name of Medical doctor: ____

Address: ____

May we contact your medical doctor? Y / N

Date of last physical or visit to M.D. (dd/mm/yy): ____/____/____

Date of last dental exam (dd/mm/yy): ____/____/____

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

For what condition? _________________________ Results: ________________________

Were any X-rays taken? _ Yes, when? _____________________________

Of which body part? __________________

When was your last appointment? ____

Reason for leaving ____

Personal information collected, used, stored and disclosed by this medical practice is confidential information.

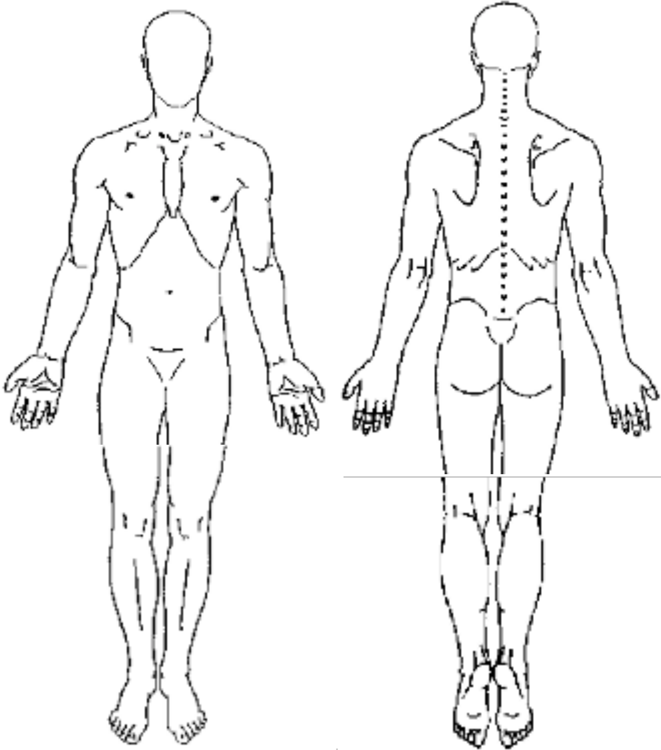
24hrs notice is required to cancel or change appointments otherwise full charges apply.

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? ____

Arthritis

Have you ever been diagnosed with arthritis? _ Y/_ N
Do you frequently suffer from joint pain, inflammation, or joint stiffness?_ Y/_ N

Lifestyle Habits

Do you smoke? _ Y/_ N How many packs per day? ______ #of years _____

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

Do you drink coffee? _ Y/_ N How many cups per day? ___________________

Rate your diet: Poor Fair Medium Good Excellent
How many glasses of water do you drink per day? ______

Any trouble sleeping? __Y/__N

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

Cardiovascular system

Do you have a history of (please circle):

High cholesterol High Blood Pressure Heart Attack
Angina Heart Surgery Diabetes

Has your mother, father, a brother or sister developed heart problems before the age of 60? _ Y/_ N

Questions for women only

Has your doctor ever indicated that you have osteoporosis? _ Y/_ N

Does osteoporosis run in your family? _ Y/_ N

Have you had a bone density test in the past two years? _ Y/_ N

Are you pregnant or planning pregnancy? _ Y/_ N

Do you have any problems with your breasts, menstrual cycle, Menopause?
_ Yes (Please describe) _____________________________________ _ No

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. ____

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

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this____________ day of________________________, 20______.

____
Patient Signature (Legal Guardian)

____
Witness of Signature

Name:________________________
(please print)

Name:________________________
(please print)