Confidential Patient Health Record

Patient information

Date: _______/________/__________

Name: ____

Address: ____

City: _______________________________ Province: ________ Postal Code: _________________________

Telephone: Home _______________________________ Work ____________________________________

Cell: ____________________________________ Email: ____

Date of birth (dd/mm/yy) ________/________/_______ Age: _________ Marital Status: S M C D W

Number of children: _________________ Age of children: _______________________________________

Employer: ___________________________________ Occupation: __________________________________

Emergency Contact: _______________________________________ Phone: ___________________________

Relationship to contact: _______________________________

Name of Medical Doctor: ____

Address: ____ May we contact your doctor? Y / N

Date of last visit to your medical doctor: _____/_____/_____ Date of last dental exam: ___/_____/______

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

For what condition?_______________________________ Results?__________________________________

Last appointment _____________ Reason for leaving?____

Are you coming here regarding an injury from a recent motor vehicle accident? Y / N or a workplace accident/injury? Y / N. If yes , Date:_________________________

How did you hear about the clinic? Internet___ Ad__ Doctor ___ Other ___ Friend(name) ____________

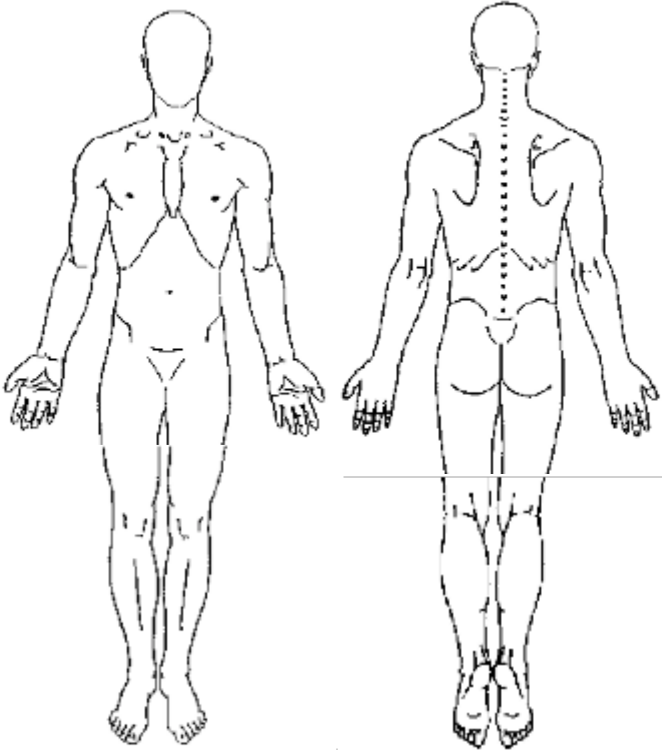
Personal information collected, used, stored and disclosed by this medical practice is confidential information.
24hrs notice is required to cancel or change appointments otherwise full charges apply.

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? ____

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

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

Have you been diagnosed with any of the following (please circle all that apply):

IBS Chron's Psoriatic arthritis Rheumatoid arthritis Osteoarthritis Fibromyalgia

High Cholesterol High Blood pressure Heart Attack Angina Heart Surgery Diabetes

Stroke Deep vein thrombosis Blood Clotting Disorder TIA Cancer Gout

Lifestyle Habits

Do you smoke? Y/ N How many per day? ________ #of years _____ Have you ever smoked? Y / N

If yes, when did you quit? ________ How much did you smoke? ________ # of years __________

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

Do you drink coffee? Y / N #cups per day? ______ Do you drink pop/soda? Y / N # per day ________

Rate your diet: Poor Fair Medium Good Excellent

Any trouble sleeping? Y / N If yes, reason ____________________________________

Do you exercise regularly? Y / N Types of exercise frequently performed:

____

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. ____

Questions for women only

Has your doctor ever indicated that you have osteoporosis? Y / N Does it run in your family? Y/ N

Have you had a bone density test in the past two years? Y / N . If yes, results?____________________

Are you pregnant or planning pregnancy? Y / N

Do you have any problems with your breasts, menstrual cycle, Menopause? Y / N

if yes, please describe ____

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.

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