Dr. Bonnie Keys, D.C. Dr. Ada Law, D.C.

511 Edinburgh Road S. Ste 101, Guelph, ON N1G 4S5
Ph:519-837-9711 Fx:519-837-8852 Email: keyslawchiro@gmail.com

PATIENT ENTRANCE FORM

Name:_____ Date:_____

Address:_____

City, Province:_____ Postal Code:_____

Home Tel:_____ Cell:_____ Bus:_____

Email:_____

Date of Birth (D/M/Y):_____ Age:_____ Marital Status –S M D W S

Spouse's Name:_____ Children:_____

Occupation (Your):_____

Employer:_____

Address:_____

City:_____ Phone:_____

Closest Relative:_____ Phone:_____

Extended Health Care Company:_____

Policy #:_____ Member ID#_____

How did you hear about our office? Friend___ Phone Book___ Sign___ Website___ Other___

CLAIM WILL BE MADE AGAINST:

1. Recent motor vehicle accident: Yes No
2. Work Related Injury/Accident: Yes No

PRIOR CHIROPRACTIC CARE:

Name: _____ Telephone:_____

X-Rays taken: YES NO Date:_____

Results: Excellent Good Fair Poor

MEDICAL DOCTOR:

Name:_____ Telephone:_____

Address:_____

Date of Last Appointment:_____ Date of Last Physical:_____

Reason for consulting this office: _____

_____

_____

Expectations: _____

Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas radiation. Include all affected areas.

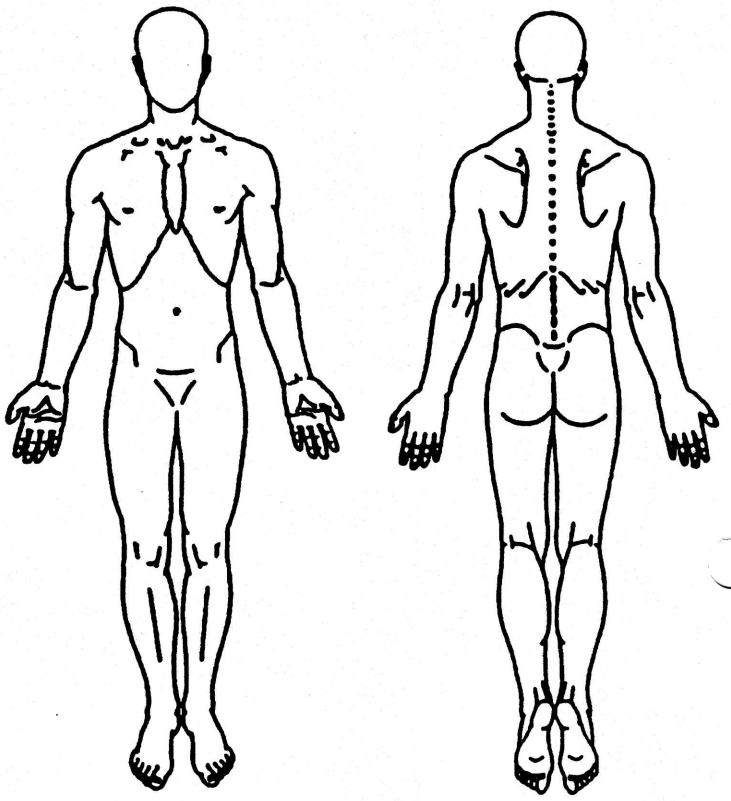
Numbness • • • • •
• • • • •
• • • • •

Pins & Needles 0 0 0 0 0
0 0 0 0 0
0 0 0 0 0

Burning X X X X X
X X X X X
X X X X X

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /
/ / / / /



Have you ever had any of the following:

aneurysm _____ ostheoporosis _____ diabetes _____ arthritis _____

respiratory conditions _____ epilepsy _____ cancer _____

strokes _____ allergies _____ heart conditions _____

hepatitis _____ nerves _____ fatigue _____ polio _____

sleeping difficulty _____ pneumonia _____ pleurisy _____

asthma _____ V.D. _____ psoriasis _____ HIV _____

sinus conditions _____

Childhood conditions had, please check:

- ❑ measles
- ❑ mumps
- ❑ chicken pox
- ❑ whooping cough
- ❑ scarlet fever
- ❑ diphtheria
- ❑ rheumatic fever
- ❑ typhoid fever
- ❑ ear infections
- ❑ tubes in ears
- ❑ chronic ill

Side 2

PATIENT PAST HISTORY FORM

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional F = Frequent C = Constant

O	F	C	
❑	❑	❑	allergy
❑	❑	❑	chills
❑	❑	❑	convulsions
❑	❑	❑	dizziness
❑	❑	❑	fainting
❑	❑	❑	fevers
❑	❑	❑	headaches
❑	❑	❑	loss of sleep
❑	❑	❑	nervousness
❑	❑	❑	depression
❑	❑	❑	neuralgia
❑	❑	❑	numbness
❑	❑	❑	sweats
❑	❑	❑	loss of weight
❑	❑	❑	tremors

MUSCLE & JOINT

❑	❑	❑	arthritis
❑	❑	❑	bursitis
❑	❑	❑	foot trouble
❑	❑	❑	hernia
❑	❑	❑	low back pain
❑	❑	❑	neck pain
❑	❑	❑	neck stiffness
❑	❑	❑	pain between shoulders

RESPIRATORY

❑	❑	❑	chest pain
❑	❑	❑	chronic cough
❑	❑	❑	difficulty breathing
❑	❑	❑	spitting blood
❑	❑	❑	throat phlegm
❑	❑	❑	wheezing

EYES, EARS, NOSE & THROAT

❑	❑	❑	colds
❑	❑	❑	crossed eyes
❑	❑	❑	deafness
❑	❑	❑	dental decay
❑	❑	❑	asthma
❑	❑	❑	ear aches
❑	❑	❑	ear discharges
❑	❑	❑	ear noises

O	F	C	
❑	❑	❑	sinus infections
❑	❑	❑	enlarged glands
❑	❑	❑	enlarged thyroid
❑	❑	❑	sore throats
❑	❑	❑	tonsillitis
❑	❑	❑	eye pain
❑	❑	❑	failing vision
❑	❑	❑	far sighted
❑	❑	❑	gum trouble
❑	❑	❑	hay fever
❑	❑	❑	hoarseness
❑	❑	❑	nasal obstruction
❑	❑	❑	near sighted
❑	❑	❑	nosebleeds

CARDIO-VASCULAR

❑	❑	❑	rapid heart beats
❑	❑	❑	slow heart beat
❑	❑	❑	swelling of ankles
❑	❑	❑	hardening of arteries
❑	❑	❑	high blood pressure
❑	❑	❑	low blood pressure
❑	❑	❑	pain over heart
❑	❑	❑	poor circulation

GASTRO INTESTINAL

❑	❑	❑	excessive hunger
❑	❑	❑	burping or gas
❑	❑	❑	liver trouble
❑	❑	❑	colitis
❑	❑	❑	colon trouble
❑	❑	❑	constipation
❑	❑	❑	diarrhea
❑	❑	❑	difficult digestion
❑	❑	❑	distension of abdomen
❑	❑	❑	stomach pain
❑	❑	❑	gall bladder trouble
❑	❑	❑	hemorrhoids
❑	❑	❑	intestinal worms
❑	❑	❑	jaundice
❑	❑	❑	poor appetite
❑	❑	❑	nausea
❑	❑	❑	vomiting
❑	❑	❑	vomit blood

O	F	C	
			SKIN
❑	❑	❑	boils
❑	❑	❑	bruise easily
❑	❑	❑	dryness
❑	❑	❑	hives or allergy
❑	❑	❑	itching
❑	❑	❑	skin rash
❑	❑	❑	varicose veins

GENITO-URINARY

❑	❑	❑	bet wetting
❑	❑	❑	blood in urine
❑	❑	❑	frequent urination
❑	❑	❑	loss control urine
❑	❑	❑	kidney infection
❑	❑	❑	painful urination
❑	❑	❑	prostate trouble
❑	❑	❑	pus in urine
❑	❑	❑	smell of urine

PAIN OR NUMBNESS IN:

❑	❑	❑	shoulders
❑	❑	❑	arms
❑	❑	❑	hands
❑	❑	❑	hips
❑	❑	❑	legs
❑	❑	❑	knees
❑	❑	❑	ankles
❑	❑	❑	feet
❑	❑	❑	painful tail bone
❑	❑	❑	sciatica
❑	❑	❑	swollen joints

FOR WOMEN ONLY

❑	❑	❑	cramps
❑	❑	❑	heavy flow
❑	❑	❑	light flow
❑	❑	❑	irregular cycle
❑	❑	❑	painful cycle
❑	❑	❑	discharge
❑	❑	❑	sore breasts

Menopausal: ❑ Yes ❑ No

Last menstration date:

_____

Pregnant: ❑ Yes ❑ No

due date: _____

SIDE 1

PATIENT PAST HISTORY FORM (continued)

HABITS OF LIFESTYLE:

Do you smoke: ❑ Yes ❑ No Do you consume alcohol: ❑ Yes ❑ No

Do you exercise: ❑ Yes ❑ No Exercise Indoor Activities:

Exercise Oudoor Activities: _____

Rate your sleep, hours per night: 4 - 6 6 - 8 8 - 10 12+

Do you wake rested: ❑ Yes ❑ No

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Do you eat per day: 1 meal 2 meals 3 meals 4 meals More than 4 meals

Date of last Dental Examination: _____

Falls and Accidents - list: _____

_____

Surgery and Operations - list: _____

_____

Surgery recommended but not performed, list: _____

_____

Do you take vitamins and minerals, list: ❑ Yes ❑ No

_____

Have you ever been knocked unconscious: ❑ Yes ❑ No ❑ Don't know

If so, for how long: _____

List any medication or drugs you are currently taking: _____

_____

_____

Have you previously been hospitalized: ❑ Yes ❑ No

Please list: _____

Any family health conditions or problems: ❑ Yes ❑ No

Please list: _____

Signature: _____ Date: _____

SIDE 2

DR. BONNIE KEYS, D.C.
DR. ADA LAW, D.C.
511 Edinburgh Road S., Suite 101, Guelph, ON N1G 4S5
Ph: (519) 837-9711 Fx: (519) 837-8852

Please rate your pain as follows:

No Pain Worst Pain
0 ---------- 10

DAY	0	1	2	3	4	5	6	7	8	9	10
NIGHT	0	1	2	3	4	5	6	7	8	9	10
SITTING	0	1	2	3	4	5	6	7	8	9	10
STANDING	0	1	2	3	4	5	6	7	8	9	10
WALKING	0	1	2	3	4	5	6	7	8	9	10
WORKING	0	1	2	3	4	5	6	7	8	9	10
SLEEPING	0	1	2	3	4	5	6	7	8	9	10

Patient Name: _____

Date: _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____ 20____
Signature of Chiropractor

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent for Acupuncture Care FORM - AC

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above-named doctor or another duly authorized doctor in the clinic.

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, possible perforation of internal organs, and stuck or bent needles.

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

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 have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

READ BEFORE SIGNING

Date Signed	Print Patient's Name	Signature of Patient (or parent/guardian)