

Date: \_\_\_\_\_ **Alberta Health Care Number:** \_\_\_\_\_

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Children: \_\_\_\_\_

**CONTACT INFORMATION**

	Number	Extension
Home:	_____	_____
Phone (bus):	_____	_____
Phone (cell):	_____	_____
Fax:	_____	_____
Email Address:	_____	

**REFERRAL INFORMATION**

- |                                                   |                                        |
|---------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Personal Referral: _____ | <input type="checkbox"/> Internet      |
| <input type="checkbox"/> Doctor Referral: _____   | <input type="checkbox"/> Phone Book    |
| <input type="checkbox"/> Physiotherapist: _____   | <input type="checkbox"/> Walk-In       |
| <input type="checkbox"/> Massage Therapist: _____ | <input type="checkbox"/> Welcome Wagon |
| <input type="checkbox"/> Midwife / Doula: _____   | <input type="checkbox"/> Other _____   |

**YOUR HEALTH CARE TEAM**

Family Doctor: \_\_\_\_\_ Massage Therapist: \_\_\_\_\_  
Naturopath: \_\_\_\_\_ OB/GYN: \_\_\_\_\_  
Midwife/Doula: \_\_\_\_\_ Other Care Providers: \_\_\_\_\_

**INSURANCE**

Do you have Extended Health Coverage?  Yes  No  
Insurance Company: \_\_\_\_\_

**Motor Vehicle Accident** (if applicable)

Are you seeking treatment for a Motor Vehicle Accident?  Yes  No

Date of Motor Vehicle Accident: \_\_\_\_\_

Have you seen another practitioner in regards to this accident?  Yes  No

Type of practitioner:  Physiotherapist  Medical Doctor  Chiropractor

Name of Practitioner: \_\_\_\_\_ Date of Assessment: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Claim Worker: \_\_\_\_\_ Claim #: \_\_\_\_\_

# CURRENT HEALTH CONDITION

---

Purpose of this Appointment: \_\_\_\_\_

Major Complaint: \_\_\_\_\_

Explain How Complaint Occurred: \_\_\_\_\_

When did this condition begin?: \_\_\_\_\_

Condition has persisted for:     Days     Weeks     Months     Years

Condition developed from:     Auto Accident     Work Injury     Other Injury \_\_\_\_\_

**Symptoms**     Came on suddenly     Come & Go

---

What activities make this condition better? \_\_\_\_\_

What activities make this condition worse? \_\_\_\_\_

Symptoms are BETTER in:     AM     Midday     PM

Symptoms are WORSE in:     AM     Midday     PM     Do not change with time of day

Have you ever had this condition before?     No     Yes, when \_\_\_\_\_

Other doctors seen for this condition: \_\_\_\_\_

Describe other complaints involving:

Neck/Head: \_\_\_\_\_

Mid-back/Shoulders/Arms: \_\_\_\_\_

Low-back/Hips/Legs: \_\_\_\_\_

Medications/supplements/vitamins you are taking: \_\_\_\_\_

For what conditions: \_\_\_\_\_

**Women:** Are you pregnant?  Yes  No    How many weeks? \_\_\_\_\_ Due Date: \_\_\_\_\_

## INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

---

**U – Unable    P – Painful    D – Difficult    L – Limited    N – Normal**

\_\_\_\_ Coughing or Sneezing

\_\_\_\_ Getting in or out of car

\_\_\_\_ Turning over in bed

\_\_\_\_ Walking short distances

\_\_\_\_ Standing more than 1 hour

\_\_\_\_ Sitting at table

\_\_\_\_ Lying on back

\_\_\_\_ Lying flat on stomach

\_\_\_\_ Lying on side w/ Knees bent

\_\_\_\_ Bending over forward

\_\_\_\_ Climbing

\_\_\_\_ Kneeling

\_\_\_\_ Balancing

\_\_\_\_ Dressing self

\_\_\_\_ Sleeping

\_\_\_\_ Stooping

\_\_\_\_ Gripping

\_\_\_\_ Pushing

\_\_\_\_ Pulling

\_\_\_\_ Reaching

\_\_\_\_ Sexual Activity

\_\_\_\_ Holding child

\_\_\_\_ Carrying car seat

---

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (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 types of care. As your doctor will weigh your needs and desires when recommending your schedule of care, please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care     Corrective Care     Preventative Care     Check here if you want the doctor to select type of care appropriate for your condition

I confirm that the information I have provided in regards to my current condition and past health history is true and complete to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# PAST HEALTH HISTORY

---

## CHECK ANY DISEASE / ILLNESS YOU HAVE HAD:

---

- |                                          |                                    |                                       |                                       |
|------------------------------------------|------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Measles   | <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Mumps        | <input type="checkbox"/> Chrohns      |
| <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chicken Pox  | <input type="checkbox"/> Colitis      |
| <input type="checkbox"/> A.I.D.S.        | <input type="checkbox"/> Influenza | <input type="checkbox"/> Cancer _____ |                                       |

## CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE and UNDERLINE THOSE YOU HAVE HAD IN THE PAST:

---

### MUSCULO-SKELETAL

- Low back pain
- Pain between shoulders
- Neck pain
- Arm pain
- Joint pain/Stiffness
- Walking problems
- difficult chewing/Clicking jaw
- General stiffness

### NERVOUS SYSTEM

- Nervousness
- Numbness \_\_\_\_\_
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling extremities
- Stress

### GENERAL

- Fatigue
- Loss of sleep
- Headaches
- Fever
- Poor appetite
- Allergies \_\_\_\_\_

### FAMILY HISTORY (for example, Cancer/ Diabetes/Heart Problems/Back or Neck Pain)

Father: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Brothers: \_\_\_\_\_  
Sisters: \_\_\_\_\_

### CARDIO-VASCULAR

- Blood pressure problems
- Heart problems
- Lung problems/Congestion
- Stroke
- Chest pains
- RESPIRATORY**
- Asthma
- Difficulty Breathing

### DIGESTIVE TRACT

- Nausea
- Heartburn
- Gas/Bloating after meals
- Constipation
- Diarrhea
- Bowel infections
- Weight issues

### GENITO-URINARY

- Bladder issues
- Painful Urination
- Excessive urination
- Yeast infections

### HABITS

- Caffeine: cups/day: \_\_\_\_\_
- Smoking: packs/day: \_\_\_\_\_
- Drinking: alcohol/wk: \_\_\_\_\_
- Fast Food: meals/wk: \_\_\_\_\_
- Junk Food: items/wk: \_\_\_\_\_
- Sleep: hours/night: \_\_\_\_\_
- Stress: low moderate high

### MALE/FEMALE

- Menstrual Irregularity
- Menstrual cramping
- Vaginal pain/Infections
- Breast pain/Lumps
- Miscarriage
- Difficulty Conceiving
- Endometriosis/ovarian cysts

### EYE/EAR/NOSE/THROAT

- Vision problems
- Sore throat
- Stuffed nose and sinuses
- Hearing difficulty
- Ear aches
- Ear infections

### EXERCISE (check one)

- none     moderate     daily
- What? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### DIET

- Poor
- Average
- Healthy (low fat, balanced meals)
- Organic
- Vegetarian

---

Have you had previous Chiropractic Care? Yes No Dr. \_\_\_\_\_

List all accident or falls: \_\_\_\_\_

Surgeries/ Operations: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Date of last spinal X-rays: \_\_\_\_\_ Location?: \_\_\_\_\_

---

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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 rather, recent studies indicate 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 following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or 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 Signature

Name: \_\_\_\_\_  
(Please Print)

Name: \_\_\_\_\_  
(Please Print)

---