Personal Health History

Name: _____ Date of Birth: _____ Age: _____
(Month / Day / Year)

Address:_____ City & Prov :_____

Postal Code: _____ Email Address: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: S M D W C Number of Children & Ages: _____

Care Card #: _____ Name of M.D.: _____

How do you wish to be addressed? ☐First Name ☐ Mr. ☐ Miss ☐ Mrs. ☐Ms. ☐Dr. ☐ Other _____

We would like to thank whoever referred you to our office: _____

Past Health History

Birth

o Birth Trauma (Caesarian, forceps, etc.) _____

Growth and Development Stage (0-18 Years of Age)

o Injury to Head / Face / Neck _____
o Injury to Back / Hip / Tailbone _____
o Injury to Leg / Knee / Ankle / Foot _____
o Sports Injuries _____
o Physical or Mental Abuse _____
o Significant Illnesses _____
o Surgery _____
o Other _____

Adulthood (18 Years and Over)

o Injury to Head / Face / Neck _____
o Injury to Back / Hip / Tailbone _____
o Injury to Leg / Knee / Ankle / Foot _____
o Work Related Injuries _____
o Motor Vehicle Accidents _____
o Sports Injuries _____
o Physical or Mental abuse _____
o Surgery _____
o Other _____

Present Health History

Lifestyle

	HEALTHY										UNHEALTHY
Smoking	0	1	2	3	4	5	6	7	8	9	10
Alcohol	0	1	2	3	4	5	6	7	8	9	10
Diet	0	1	2	3	4	5	6	7	8	9	10
Exercise	0	1	2	3	4	5	6	7	8	9	10
Physical Stress	0	1	2	3	4	5	6	7	8	9	10
Mental Stress	0	1	2	3	4	5	6	7	8	9	10
Overall Health	0	1	2	3	4	5	6	7	8	9	10

Present Condition

Present Complaint _____

When did this problem start? _____

What movements/activities aggravate your condition? _____

What movements/activities lessen your condition? _____

Is your condition worse at certain times of the day? _____

Is this condition interfering with **work**? ____ **Sleep?** ____ **daily routine**?____ **other**____

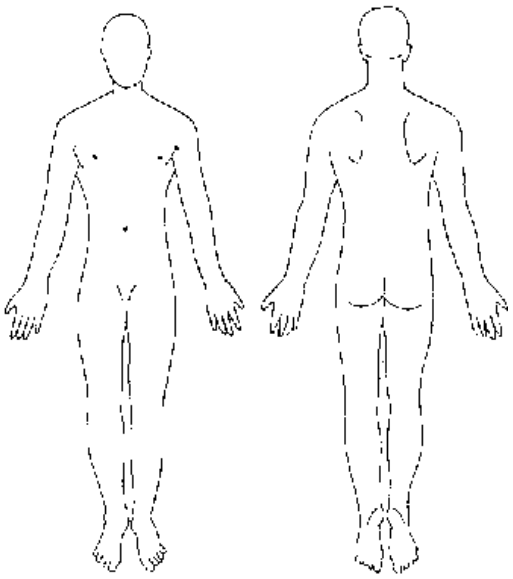
Is this condition getting progressively **better**?___ **getting worse**?___ **same**?___

Other health professionals seen for this condition?

_____

Any home remedies tried? (Ex: ice, heat, stretching, etc.)

_____



PLEASE MARK YOUR AREAS OF COMPLAINT ON THIS DIAGRAM

Other Symptoms

☐ Headaches	☐ Pins & Needles in Legs/Feet	☐ Fainting
☐ Neck Pain	☐ Pins & Needles in Arms/Hands	☐ Loss of Smell
☐ Sleeping Problems	☐ Numbness in Legs/Feet	☐ Loss of Taste
☐ Back Pain	☐ Numbness in Arms/Hands	☐ Diarrhea
☐ Nervousness	☐ Shortness of Breath	☐ Constipation
☐ Tension	☐ Fatigue	☐ Cold Feet
☐ Irritability	☐ Depression	☐ Cold Hands
☐ Chest Pain	☐ Lights Bother Eyes	☐ Stomach Upset
☐ Dizziness	☐ Loss of Memory	☐ Cold Sweats
☐ Ears Ring/Buzz	☐ Fever	☐ Loss of Balance

PATIENT / DOCTOR AGREEMENT

OFFICE VISIT FEES			
First Visit	$80	Premium Assistance (1-10 visits)	$25
Subsequent Visit	$55	Premium Assistance (11+ visits)	$55

These fees are payable when services are rendered. Most "Extended Health Plans" include coverage for chiropractic care. If you have a plan, check to determine the extent of your coverage. These fees do not apply to ICBC or WCB patients. You, the patient, are ultimately responsible for your account with us in the event that your insurance does not pay for any reason.

RISKS

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's Name (Please Print)	Patient's Signature (Or Parent / Guardian)	Chiropractor Signature