Practice Address: 11157 Ellerslie Road SW, Edmonton

Patient Case History

***Required** *All information contained in this questionnaire is strictly confidential.*

***Full Name:** *** Date of Birth(dd/mm/yyyy):**

***Gender:** ☐ **M** ☐ **F** **Preferred Pronouns :** (optional) ***AHC#:**

***Full Mailing Address:** *** Postal Code:**

***Phone:** (Cell) (W) (H)

Do you want to receive appointment reminders via text message? Y ☐ N☐ you can unsubscribe from these messages at any time

Email Address: (optional) By providing your email address you consent to receive email communication from Jackson Chiropractic, you can unsubscribe from these emails at any time.

***Occupation** **Employer:**

Is this a work related injury? Y ☐ N☐ **Has a WCB claim been started?** Y☐ N☐ **if no, do you plan on submitting a claim?** Y☐ N☐

Are Extended Health Benefits available? Y ☐ N ☐ **Benefits Company:**

Are you: **Please ✓** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Common-Law ☐ Other

Spouse/Partner's Name: **Children's Name(s):**

Who may we thank for referring you to our Practice? ☐ Signage ☐ Website ☐ Google ☐ Family/Friend – Name:

***Emergency Contact** (Name) (Tel)

Your Health Profile

Why this form is important. As a full spectrum Chiropractic Office, we focus on your ability to be healthy. Throughout life, events/stresses occur (physical, chemical and emotional) which damages your health expression. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, especially to your nervous system, allowing us to better access the challenges to your health potential.

If you have ever had Chiropractic Care, please complete the following.

Name of Chiropractor: Located where?

Why did you seek Chiropractic Care? Date of last Adjustment:

What were the results of your Care? ☐ Excellent ☐ Satisfactory ☐ Fair ☐ Did not help ☐ Worsened

Did the Chiropractor take X-Rays? ☐ Yes ☐ No Did you have a thorough examination? ☐ Yes ☐ No

Addressing the issues that brought you to this office.

Please describe the **chief area/s** of your complaint:

If you are experiencing pain, is it? ☐ Sharp ☐ Dull ☐ Comes and goes ☐ Constant

Since the problem started, is it? ☐ About the same ☐ Getting better ☐ Getting worse

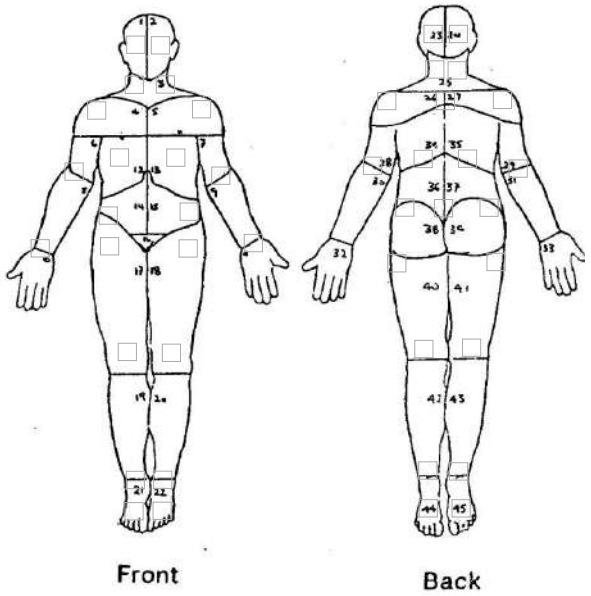
It interferes with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure ☐ Other

If, other please describe:

Currently your symptoms are aggravated by:		
☐ Bending	☐ Reaching	☐ Straining at stool
☐ Coughing	☐ Sitting	☐ Walking
☐ Lifting	☐ Sneezing	☐ Other
☐ Neck movement	☐ Standing	

Currently your symptoms are relieved by:		
☐ Rest	☐ Ice	☐ Massage
☐ Standing	☐ Heat	☐ Stretch
☐ Sitting	☐ Movement	☐ Other

On the drawings to the right please circle affected areas, rate pain 0-10, and indicate how long you have had it.



Front Back

Systems Review

*Name*_____*Date*_____

GENERAL SYMPTOMS

	Past	Pres.
Fever	☐	☐
Sweats	☐	☐
Fainting	☐	☐
Sleep Disturbance	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Weight Loss	☐	☐
Weight Gain	☐	☐
Depression	☐	☐

RESPIRATORY

	Past	Pres.
Chronic cough	☐	☐
Spitting up phlegm	☐	☐
Spitting up blood	☐	☐
Chest pain	☐	☐
Wheezing	☐	☐
Difficulty breathing	☐	☐
Asthma	☐	☐

GENITOURINARY

	Past	Pres.
Frequent urination	☐	☐
Painful urination	☐	☐
Blood in urine	☐	☐
Pus in urine	☐	☐
Kidney infection	☐	☐
Prostate trouble	☐	☐
Uncontrollable urine flow	☐	☐

NEUROLOGICAL

	Past	Pres.
Visual Disturbance	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Convulsions	☐	☐
Headache	☐	☐
Per Week _____Per Month_____		
Numbness	☐	☐
Nerve Pain	☐	☐
Poor coordination	☐	☐
Weakness	☐	☐
Loss of balance	☐	☐

CARDIOVASCULAR

	Past	Pres.
Slow beating heart	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Pain over heart	☐	☐
Hardening of arteries	☐	☐
Pace Maker	☐	☐
Varicose veins	☐	☐
Swollen ankles	☐	☐
Poor circulation	☐	☐
Palpitations	☐	☐
Cold hands or feet	☐	☐

GASTROINTESTINAL

	Past	Pres.
Poor appetite	☐	☐
Difficult digestion	☐	☐
Heartburn	☐	☐
Ulcers	☐	☐
Nausea	☐	☐
Colitis	☐	☐
Vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Blood in stool	☐	☐
Gallbladder/ jaundice	☐	☐

EENT

	Past	Pres.
Eye pain	☐	☐
Double vision	☐	☐
Ringing in ears	☐	☐
Deafness	☐	☐
Nosebleeds	☐	☐
Trouble swallowing	☐	☐
Hoarseness	☐	☐
Sinus infection	☐	☐
Nasal drainage	☐	☐
Enlarged glands	☐	☐

MUSCLE & JOINT

	Past	Pres.
Neck	☐	☐
pain ☐ stiff ☐		
Low back	☐	☐
pain ☐ stiff ☐		
Arm Pain	☐	☐
Shoulder pain	☐	☐
Leg pain	☐	☐
Knee pain	☐	☐
Foot pain	☐	☐
Pain/ numbness down;	☐	☐
Arms ☐ Legs ☐ Hands ☐	Feet ☐	
Pain between shoulders	☐	☐
Swollen joints	☐	☐
Spinal curvature	☐	☐
Arthritis	☐	☐

FOR WOMEN ONLY

	Past	Pres.
Painful menstruation	☐	☐
Cramps or back pain	☐	☐
Nipple discharge	☐	☐
Menopausal symptoms	☐	☐
Birth control pills	☐	☐
Miscarriages	☐	☐
Pregnancy complications	☐	☐

Pregnant?

Yes ☐ No ☐

Your Childhood Years (to age 17)			
When you were born was your birth process difficult? ☐ Yes ☐ No ☐ Unsure			
Did you participate in aggressive youth sports? ☐ Yes ☐ No ☐ Unsure			
Did you have any childhood illnesses? ☐ Yes ☐ No ☐ Unsure			
Was there any prolonged use of medication such as antibiotics or an inhaler? ☐ Yes ☐ No ☐ Unsure			
As a child, were you under regular Chiropractic Care? ☐ Yes ☐ No ☐ Unsure			
Did you have any serious falls/injuries as a child? ☐ Yes ☐ No ☐ Unsure	If Yes, What and When:		
Did you have any surgery? ☐ Yes ☐ No ☐ Unsure	If Yes, What and When:		

Your Adult Years (18 years to present)							
Have you had any serious health problems? ☐ Yes ☐ No ☐ unsure							
Have you been in any motor vehicle, motor bike accidents or major falls? ☐ Yes ☐ No ☐ unsure If Yes, What and When:							
Have you fractured or broken any bones? ☐ Yes ☐ No ☐ Unsure	If Yes, What and When:						
Have you had any surgery or been in hospital? ☐ Yes ☐ No ☐ Unsure If Yes, What and When							
On a scale of **1 – 10**, describe your **stress levels** (1 = zero 10 = Extreme) Occupational: Personal:							
	Never	Occasionally	Moderately	Excessive		Poor	Good	Excellent
Alcohol	☐	☐	☐	☐	Diet	☐	☐	☐
Smoking	☐	☐	☐	☐	Exercise	☐	☐	☐
Coffee	☐	☐	☐	☐	Sleep	☐	☐	☐
Sodas	☐	☐	☐	☐	General Health	☐	☐	☐
MEDICATIONS	**Are you currently taking any of the following?**							
☐ Anti-inflammatory ☐ Muscles relaxants ☐ Pain medication ☐ Anti-depressants ☐ Vitamins ☐ Birth Control ☐ Blood Pressure							
☐ Other. Please list:							
Medical Doctor's Name:							

Family Health Profile	
At our office we are not only interested in your health and well-being, but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:	
Mother:	Father:
Spouse:	Children:
Others:	

Lifestyle Profile
What do you want to gain from Chiropractic Care?
What are your ultimate health goals/desired outcome?
What is your passion in life? Hobbies/Special interests.

For Women					
Are you pregnant? ☐ Yes ☐ No ☐ Unsure	Date of last menstrual cycle:				
Please ✓ if you have the following:	☐ Painful or tender breasts	☐ Lumps in breast	☐ Period pain	☐ Irregular periods	
☐ Hot flushes	☐ Painful intercourse	☐ Bleeding between periods	☐ Excessive menstrual flow	☐ Vaginal discharge	

PLEASE READ AND SIGN	
The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and to take 'specific postural x-rays' if required.	
Name:	**Date:**
Signature of patient (or legal guardian**):**	

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

JACKSON CHIROPRACTIC

Updated: September 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____ _____ _____
Patient/Guardian Signature Date Chiropractor Signature