Practice Address: 11157 Ellerslie Rd SW, Edmonton

Patient Case History

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

***Full Name:** *** Date of Birth(dd/mm/yy):** ***Gender: M F Other**

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

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

Email Address: (Optional) ***AHC#:**

By providing your email address you consent to receive email communication from Jackson Chiropractic including appointment reminders, posture screening results, birthday emails and newsletters, 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 ☐ **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? ☐Phone Book ☐ 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

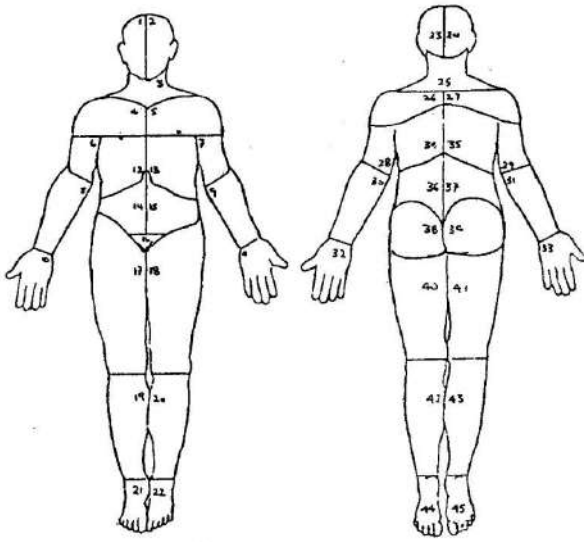
It interferes with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure ☐ Other

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*_____

Please **circle** any conditions that are **presently** causing you a problems and **underline** those that have caused you problems in the **PAST.**

GENERAL SYMPTOMS	**RESPIRATORY**	**GENITOURINARY**
Fever Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain Depression	Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance Dizziness Fainting Convulsions Headache Per week..... Per Month..... Numbness Neuralgia (nerve pain) Poor coordination Weakness Loss of balance	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 hand or feet	Poor appetite Difficult digestion Heartburn Ulcers Nausea Colitis Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice
EENT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands	Neck pain Pain / Stiff Low back pain Pain / Stiff Arm pain Shoulder pain Leg pain Knee pain Foot pain Pain/numbness down arms or legs / hands / feet Pain between shoulders Swollen joints Spinal curvature Arthritis	Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy 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**):**	

JACKSON
CHIROPRACTIC

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 mayor 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