Live Life Better
MEMORIAL DRIVE CHIROPRACTIC & MASSAGE

#213, 5271 Memorial Drive SE
Calgary, AB T2A 4V1
403 273-0203

CONSULTATION ADMITTANCE FORM

Part 1: General Information

Date:_____ Alberta Health Care #:_____

Last Name:_____ First Name:_____

Address: _____City:_____

Postal Code: _____Home Phone: _____Work Phone: _____

Cell Phone:_____ *Email:_____
(for patient communication and appointment reminders) *Optional

Age: _____ Birth date (DD/MM/YY): _____ Height: _____ Weight:_____

Gender _____

Occupation: _____

□ Single □ Married □ Common Law □ Divorced □ Widowed # of Children:_____

Emergency Contact Name/ Number:_____

How did you hear about us?_____

Is this condition related to: Work? □ Yes □ No has your employer been notified? □ Yes □ No

Motor vehicle accident? □ Yes □ No Date of injury: _____

Part 2: Your Previous Spinal and Nervous System Care

WHY THIS FORM IS IMPORTANT

On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential and current concerns.

1. Have you ever had your spine or nervous system examined professionally by a Doctor of Chiropractic or other health care practitioner? □ Yes □ No

   If Yes, when and by whom? _____

2. Have you received a chiropractic spinal adjustment by a Doctor of Chiropractic? □ Yes □ No

   If yes, what was the Doctor's name and when was your last visit? _____

   How long were you receiving chiropractic adjustments? _____

3. If you stopped, why did you stop going? _____

Part 3: Your Health Concerns or Symptoms and How they May Affect Your Life

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason for appointment if not for wellness care? _____

When did your condition begin? _____

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Have you ever had similar problems? □ Yes □ No

Have you had X-rays, MRI or other tests for this condition? What tests and when? _____

Can you perform your daily home activities? □ Yes □ Yes, only with help □ Not at all

Can you perform your daily work activities? □ All activities □ only some □ Not at all

Describe your stress level: □ None □ mild □ Moderate □ High

Have you ever been diagnosed or told you have any of the following?

Please circle the correct response.

1. High blood pressure.....	Yes	No
2. Hardening of the arteries (arteriosclerosis).....	Yes	No
3. Heart Burn or GERD……..	Yes	No
4. Diabetes.....	Yes	No
5. Tuberculosis.....	Yes	No
6. Cancer, Where?	Yes	No
7. Heart or blood diseases.....	Yes	No
8. Bone spurs on the neck bones (cervical sprain).....	Yes	No
9. Whiplash injury (flexion-extension injury, cervical sprain).....	Yes	No
10. Have you or any of your relatives ever suffered a stroke?	Yes	No
11. Were you ever a smoker? From_____ To_____	Yes	No
12. Do you take any medication on a regular basis?	Yes	No
13. Visual disturbances (blurring, loss, double)….....	Yes	No
14. Hearing disturbances (loss, ringing, other noise).....	Yes	No
15. Slurred speech or other speech problems.....	Yes	No
16. Difficulty swallowing.....	Yes	No
17. Dizziness.....	Yes	No
18. Loss of consciousness, or momentary blackouts.....	Yes	No
19. Numbness, loss of sensation, strength or weakness In the face, fingers hands, arms, legs or any other parts of the body…..	Yes	No
20. Sudden collapse without loss of consciousness.....	Yes	No

21. Are you pregnant? Yes No

Due Date: _____ #of Pregnancies: _____ Live Births: ____ Miscarriages: _____

Date of Last Menstrual Period: _____

Part 4: Trauma / Medical History

1. Have you ever **broken any bones**? □ Yes □ No

   If yes, please explain:_____

2. Have you ever had any **impacts**, **falls**, or **jolts** that you feel specifically may have injured your spine?
   □ Yes □ No

   If yes, please explain: _____

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3. Have you, (even as a passenger, even if you don't think you were hurt) been involved in **a motor vehicle accident**? □ Yes □ No

   If yes, please list approximate dates and severity (mild, moderate, and severe): _____

4. Have you ever been **hospitalized**? □ Yes □ No

   If yes, please explain: _____

5. Have you ever had **surgery**? □ Yes □ No

   If yes, please explain: _____

6. Do you **read** or **work at a computer** for prolonged periods? □ Yes □ No

7. Does your job or any daily activity require **highly repetitive tasks**? □ Yes □ No

8. During the day I primarily: □ Sit □ Stand □ Walk □ Do desk work □ Phone work □ Drive □ Heavy lifting

9. I **exercise**: □ Never □ Daily □ Weekly □ Monthly Describe: _____

10. Were you or are you active in any sports? □ Yes □ No

    If yes, which ones? _____

11. Have you ever been hurt in any of these activities? □ Yes □ No

Chemical Trauma

1. Did you regularly take medications as a child? □ Yes □ No Describe: _____

2. Are you **now** taking **drugs** (prescription or over the counter) regularly? □ Yes □ No

   If yes, please list drugs and reason for taking them: _____

Is there any other history or current problem that we may not have asked about? _____

Family doctor name: _____ Last Visit: _____

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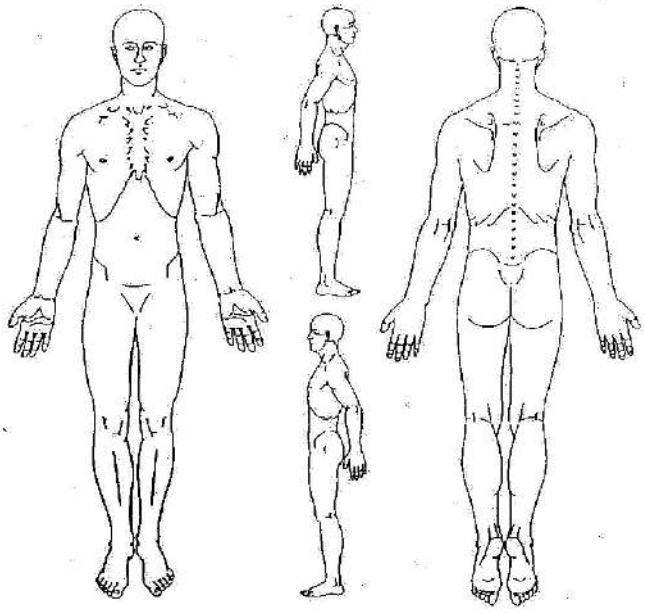
USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATIONS OF YOUR SENSATIONS RIGHT NOW

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER



Part 5: Family History

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions in your immediate family or concerns you may have about you're:

Children _____
Spouse _____
Mother _____
Father _____
Brother(s) _____
Sister(s) _____
Others _____

Date_____ Patient Signature:_____

Thank you for choosing our Chiropractic office.
We are looking forward to helping you to be successful in your ability to develop a healthy spine and nervous system.
We are excited about the possibility of assisting you as you continue your journey towards greater health and wellness.

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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 the 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 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 disk** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can error with common daily activities such as bending or lifting. Patients who already have a degenerate 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 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

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break off and travel up to 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 traveling 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 towards 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 a stroke.

The consequences of a stroke can be 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 you care. Inform your Chiropractor immediately of any change in your condition.

DO NOT SIGN 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.

_____
Name (Please Print)

_____ Date: _____20_____
Signature of patient (or legal guardian)

_____ Date: _____20_____
Signature of Chiropractor