Name: ______________________________

Date: ______________________________

File: ______________________________

Doctor: ______________________________

OFFICE USE ONLY

Our mission is to provide exceptional care and service to the families of our community, allowing them opportunities to express healthier, happier and fuller lives.

PERSONAL INFORMATION

Name: ______________________________

Address: ______________________ City: ____________ Postal Code: __________

Date of Birth: D_____ M _____ Y _________ Gender: ☐ M ☐ F ☐ Non-binary ☐ prefer not to say

Height: __________ Weight: __________ Foot size: ______________ Width: __________

No. of children (ages) ______________________________

Family Physician: __________________ Health Card Number: __________________

Occupation: __________________ Employer: __________________

How did you hear about us? ______________________________

CONTACT INFORMATION

Cell Phone: __________________ Email: __________________

Work Phone: __________________ Home Phone: __________________

How do you wish to be contacted: ☐ Cell phone ☐ Home phone ☐ Work phone ☐ Email

EMERGENCY CONTACT INFORMATION

Name: ______________________________

Relationship: __________________ Phone: __________________

Living Well Chiropractic 6 - 3695 Clarence Street, Val Caron ON P3N 1H4

Current Health Challenge

Describe the purpose of this visit: ______________________

Other health professionals seen for this problem? ☐ No ☐ Yes Who: ______________________

If Yes, Treatment received: ______________________ Results: ☐ Poor ☐ Fair ☐ Good

WHEN did this problem begin? ______________________

HOW did this problem begin? ______________________

Has this problem occurred before? ☐ No ☐ Yes When? ______________________

Did this problem begin: ☐ Gradually ☐ Suddenly

Describe your symptoms: ☐ Sharp ☐ Dull ☐ Stiff ☐ Ache ☐ Throbbing ☐ Burning ☐ Pins & Needles ☐ Numbness ☐ Other ______________________

Is your problem: ☐ Getting better ☐ Getting worse ☐ Staying the same

Is your problem: ☐ Constant ☐ Comes and goes

Is the intensity of your pain: ☐ Mild ☐ Moderate ☐ Severe

Does the symptom radiate elsewhere? ☐ No ☐ Yes Where? ______________________

What makes your problem feel worse ? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Stairs ☐ Driving ☐ Working ☐ Sneeze / Cough ☐ Bowel movement ☐ Other ______________________

What makes your problem feel better: ☐ Rest ☐ Ice ☐ Heat ☐ Medication ☐ Massage ☐ Stretching ☐ Exercising ☐ Other ______________________

Does this problem interfere with: ☐ Work ☐ Family / Social ☐ Hobbies / Sports ☐ Sleep ☐ Other ______________________

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem? ______________________

When was the last time you felt your best? ______________________

Do you have any other health challenges? ______________________

Chiropractic History

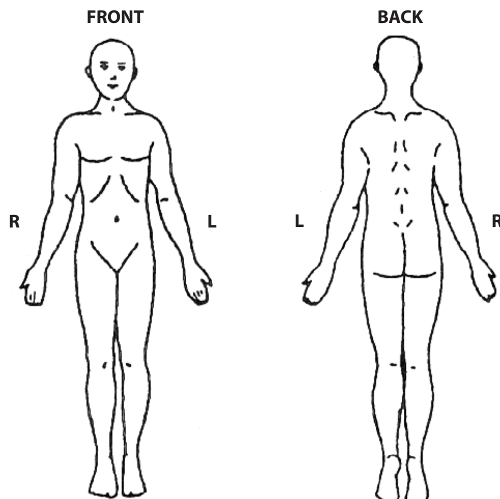
Have you had Chiropractic care in the past? ☐ Yes ☐ No

If YES: Who? ______________________ Where? ______________________

Were you adjusted? ☐ Yes ☐ No

Reason for visit? ______________________ Approximate date of last visit? ______________________

Please outline on the diagram the area of your discomfort and any radiations of pain



Family History

Has any family members had any of the following:

☐ Arthritis ☐ High Blood Pressure ☐ Diabetes ☐ Cancer

☐ Osteoporosis ☐ High Cholesterol ☐ Heart Disease

☐ Other ______________________

Past History

Major Surgery: ☐ Back Surgery ☐ Hernia ☐ Broken Bones ☐ Hysterectomy ☐ Tonsillectomy ☐ Gallbladder ☐ Other ______________________

Hospitalization (other than above) ______________________

Health Conditions

Below is a list of health conditions that may seem unrelated to the purpose of your appointment. However, this list must be answered carefully as these problems can affect your overall course of chiropractic care.
Have you ever suffered from any of these conditions – past or present?

Past	Present		Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Pneumonia	☐	☐	Tuberculosis	☐	☐	Heart disease	☐	☐	Measles	☐	☐	Prostate
☐	☐	Arthritis	☐	☐	Anemia	☐	☐	Hepatitis	☐	☐	Chicken Pox	☐	☐	Fibromyalgia
☐	☐	Cancer	☐	☐	Diabetes	☐	☐	Polio	☐	☐	Asthma	☐	☐	Eczema
☐	☐	Stroke	☐	☐	Epilepsy	☐	☐	HIV / Aids	☐	☐	Shingles			

Check any of the following you have had within the past 6 months:

☐ Low back pain	☐ Gas / Bloating	☐ Pain between shoulder blades	☐ Loss of sleep
☐ Colitis / Ulcers	☐ Joint pain / stiffness	☐ Difficulty chewing / clicking jaw	☐ Allergies
☐ Nervousness / anxiety	☐ Dizziness	☐ Confusion / Depression	☐ Frequent Nausea
☐ Fainting	☐ Loss of Balance	☐ Chest pains	☐ Gall bladder issues
☐ Heartburn	☐ Convulsions	☐ Lung problems / congestion	☐ Kidney problems
☐ Ankle swelling	☐ Neck pain / stiffness	☐ Fatigue	☐ Bladder issues
☐ Headaches	☐ Ear aches	☐ Blood pressure problems	☐ Constipation
☐ Vomiting	☐ Diarrhea	☐ Eczema	☐ Hot Flashes
☐ Pain in arms or hands	☐ Numbness in arms or hands	☐ Numbness in legs or feet	☐ Pain in legs or feet

Accident History

Have you been involved in a vehicle accident? ☐ No ☐ Yes

If YES: Date of accident:__________________________ Treatment received: __________________________

Have you been involved in a work related injury (reported or not)? ☐ No ☐ Yes

If YES: Date of injury:__________________________ Treatment received: __________________________

Have you been involved in a sports injury? ☐ No ☐ Yes

If YES: Date of injury:__________________________ Treatment received: __________________________

Do you take medications for any of the following:

☐ Diabetes	☐ Pain	☐ Blood pressure	☐ Muscle spasms
☐ Cholesterol	☐ Anxiety	☐ Blood thinners	☐ Depression
☐ Thyroid	☐ Sleeping	☐ Birth control	☐ Heart condition

☐ Other ____

Female ONLY

When was your last period?

____

Are you pregnant? ☐ No ☐ Yes ☐ Unsure

Menstrual cramping? ☐ No ☐ Yes

Breast implants? ☐ No ☐ Yes

Health Habits

Do you smoke or vape? ☐ No ☐ Yes Amount/day ____________________

Do you drink alcohol ? ☐ No ☐ Yes Amount/week ____________________

Do you drink coffee? ☐ No ☐ Yes Amount/day ____________________

Do you drink pop/sugary drinks/power drinks? ☐ No ☐ Yes Amount/day ________

Do you exercise regularly? ☐ No ☐ Light ☐ Moderate ☐ High

What are your lifestyle stress levels? ☐ Low ☐ Moderate ☐ High

Do you wear: ☐ Heel lifts ☐ Foot orthotics (prescribed or not)

Your Goals and Expectations

People go to a chiropractor for a variety of reasons. Some merely go for relief of pain, some to correct the cause of the problem and still others seek care for correction of whatever is malfunctioning in their body. Below are the three possible goals for your care. Please check your desired goal so that we may be guided by your wishes whenever possible.

☐ **PREVENTATIVE WELLNESS** - bring my body to its highest possible state of wellness.
"Once I've corrected my problem, I'd like to preserve the progress I've made and continue to improve my wellness"

☐ **CORRECTION AND STABILIZATION** - relieve and correct the cause of my condition.
"I recognize that the pain is only an alarm signal and what I really want is to correct the underlying cause of my problem."

☐ **RELIEF** - symptomatic relief of the pain and discomfort.
"I just want to get rid of the pain, without worrying about the underlying cause."

☐ **I want the doctor to guide my goal selection based on my condition.**

Authorization for Examination and Care

I hereby request and consent to the performance of chiropractic examination, adjustment and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic or staff member and/or with other office or clinic personnel, the nature and purpose for chiropractic examinations, adjustments and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, rib fractures and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known is in my best interests.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from my insurance company. I authorize the Doctor's Office to release information to my insurance company from time to time if and when my insurance company requests such. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned chiropractic procedures. I intend this consent to cover the entire course of treatment for my present condition.

Patient / Lawful representative's signature

____ Date ______________________

Witness / Attending D.C. / Assistant's signature

____ Date ______________________