Living Well
CHIROPRACTIC

3695 Clarence Street, Unit 6
Val Caron, ON
P3N 1H4

(For office use only)

Name _____

Date _____

Patient Number _____

Doctor _____

Welcome to Living Well Chiropractic

Please fill out our confidential Patient Health Questionnaire completely and accurately. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific chiropractic care.

Personal History

Name: _____

Address: _____

City: _____ Province: _____

Postal Code: _____ H. Phone: _____

Birthdate: D ____ M ____ Y _____

Foot size: _____ Width: ❒ normal ❒ wide ❒ narrow

Weight: _____ Height: _____

Family Physician: _____

Business/Employer: _____

Type of work: _____

Business Phone: _____

Cell Phone: _____

E-mail: _____

Sex: ❑ Male ❑ Female

Number of children and ages: _____

How did you find out about our office: _____

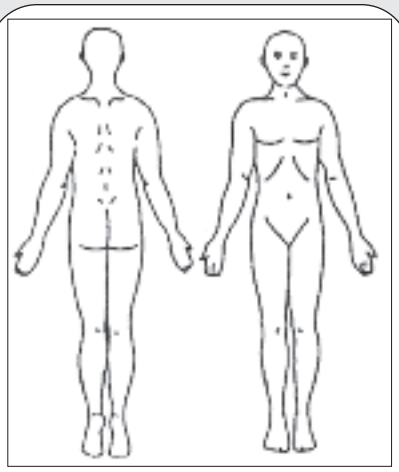
Circle one: Single Married Widowed Separated Other

Who will be financially responsible for your account?: ❑ Self ❑ Spouse ❑ Parent/Guardian

How will you be taking care of your account?: ❑ Visa ❑ MasterCard ❑ Interac ❑ Cheque ❑ Cash

Current Health Condition

Describe the purpose of this visit: _____
Other doctors seen for this condition? ❑ No ❑ Yes Who: _____
Treatment received: _____ Results: ❑ Poor ❑ Fair ❑ Good
When did this condition begin? _____ How? _____
Has this condition occurred before? ❑ No ❑ Yes When? _____
Did this condition begin: ❑ Gradually ❑ Suddenly
Describe your pain: ❑ Sharp ❑ Dull ❑ Stiff ❑ Ache ❑ Throbbing ❑ Burning
❑ Pins & needles ❑ Numbness ❑ Other _____
Is your condition: ❑ Getting better ❑ Getting worse ❑ Staying the same
Is your condition: ❑ Constant ❑ Comes and goes
Is the intensity of your pain: ❑ Mild ❑ Moderate ❑ Severe
Does the condition radiate to other areas of your body? ❑ No ❑ Yes Where? _____
What makes your condition feel worse: ❑ Sitting ❑ Standing ❑ Bending ❑ Lifting ❑ Walking
❑ Lying down ❑ Stairs ❑ Driving ❑ Working ❑ Sneeze/Cough
❑ Bowel movement ❑ Rest ❑ Medication ❑ Other _____
Any previous chiropractic care? ❑ No ❑ Yes Who/Where? _____ When? _____
Sleep posture: ❑ Side ❑ Stomach ❑ Back
If you don't get the problem corrected, do you think it will get worse during the next 5 years? ❑ Yes ❑ No
On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____
Do you suffer from any conditions other than that for which you are now consulting us? _____
When was the last time you felt your best? _____



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

Accident History

Have you been involved in a vehicle accident? ❑ Yes ❑ No
Date of accident: _____ Treatment received: _____
Was collision from ❑ Front ❑ Back ❑ Side ❑ Other _____

Have you been involved in a work injury (reported or not)? ❑ Yes ❑ No
Date of accident: _____ Treatment received: _____
Injury result of ❑ Slip ❑ Strain ❑ Twist ❑ Fall ❑ Lift ❑ Other _____

Have you been involved in a sports injury? ❑ Yes ❑ No
Date of accident: _____ Treatment received: _____

Family and Past Health History

Does any member of your family suffer from the same condition? ❑ No ❑ Yes Who? _____

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Mother's side:	❑	❑	❑	❑	
Father's side:	❑	❑	❑	❑	

Have you had major surgery? ❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Hernia
❑ Back surgery ❑ Broken bones ❑ Other _____
Hospitalization (other than above): _____ Any side effects from drugs or surgery: _____

Health Conditions

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of Chiropractic care.

Check any of the following diseases you have had

❑ Pneumonia	❑ Mumps	❑ Rheumatic Fever	❑ Pleurisy	❑ Polio	❑ Chicken Pox
❑ Arthritis	❑ Tuberculosis	❑ Diabetes	❑ Epilepsy	❑ HIV/Aids	❑ Shingles
❑ Cancer	❑ Anemia	❑ Mental Disorder	❑ Heart disease	❑ Measles	❑ Prostate
❑ Eczema	❑ Chemotherapy	❑ Whooping cough	❑ Hepatitis	❑ Asthma	❑ Fibromyalgia

Check any of the following you have had in the past six months

❑ Low back pain	❑ Gas/Bloating after meals	❑ Pain between shoulder blades	❑ Chest pain
❑ Colitis/Ulcers	❑ Joint pain/stiffness	❑ Difficulty chewing/clicking jaw	❑ Loss of sleep
❑ Nervousness	❑ Dizziness	❑ Numbness/Pain in hands/arms/legs	❑ Allergies
❑ Fainting	❑ Convulsions	❑ Confusion/Depression	❑ Frequent nausea
❑ Heartburn	❑ Neck pain	❑ Heart Problems	❑ Gall bladder problems
❑ Ankle swelling	❑ Stroke	❑ Lung problems/Congestion	❑ Kidney problems
❑ Headaches	❑ Ear aches	❑ Fatigue	❑ Bladder Trouble
❑ Vomiting	❑ Diarrhea	❑ Sinus problems	❑ Difficulty breathing
❑ Hemorrhoids	❑ Abdominal cramps	❑ Blood pressure problems	❑ Constipation

Females Only

When was your last period? _____

Are you pregnant	❑ Yes	❑ No
Birth Control:	❑ Yes	❑ No
Menstrual Irregularity:	❑ Yes	❑ No
Menstrual Cramping:	❑ Yes	❑ No
Breast Pain/Lumps:	❑ Yes	❑ No
Breast Implants:	❑ Yes	❑ No

Medications You Now Take

❑ Diabetes	❑ Painkillers
❑ Blood Pressure	❑ Muscle Relaxers
❑ Cholesterol	❑ Anxiety
❑ Blood Thinners	❑ Depression
❑ Thyroid	❑ Sleeping

❑ Other _____

Health Habits

Do you smoke?	❑ No	❑ Yes _____	packs/day
Do you drink alcohol?	❑ No	❑ Yes _____	drinks/day
Do you drink coffee/tea?	❑ No	❑ Yes _____	cups/day
Do you exercise regularly?	❑ No	❑ Moderate	❑ Frequently
Lifestyle stress levels:	❑ Low	❑ Moderate	❑ High
Do you wear	❑ Heel Lifts	❑ Arch Supports	
	❑ Prescription Foot Orthotics		

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. These are the three possible goals for your care. Your doctor will weigh your needs and desires when recommending your program of 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 condition, I'd like to preserve the progress I've made and continue to improve my wellness."

❑ CORRECTION - relieve and correct the cause of my condition.
"I recognize that the pain is only a warning signal and what I really want is to correct the underlying cause of my condition."

❑ RELIEF AND STABILIZATION - symtomatic relief of the pain and discomfort.
"I just want to get rid of the pain."

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

Authorization For Examination And Care

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 understand that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

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/staff member and/or with other office or clinic personnel, the nature and purpose for chiropractic examinations, adjustments and other procedures. I understand that 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 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 form 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 _____