Today's Date: _____

Rivergrove Chiropractic

MHSC REGISTRATION # (6 DIGIT) _____ **(9 DIGIT)** _____
First Name: _____ Last Name: _____
I am a Male/Female (circle) Birthday (d/m/y): _____/_____/_____ Current Age: _____
Street Address: _____
City: _____ Province: _____ Postal Code: _____
Home #: _____ Work #: _____ Cell #: _____
Email Address: _____
Occupation: _____ Employer: _____
Spouse's Name: _____ # of Children: ____ Ages of children: _____
Are you pregnant? Yes/No (circle)
How did you hear about us? _____

Will you be claiming: Autopac (MPI): Y/N Worker's Compensation: Y/N
If yes: Injury/Accident Date: _____ Personal Injury Claim #: _____
_____

CHIROPRACTIC HISTORY:
Have you been to a chiropractor before? Y/N Date of last visit: _____
Name of last chiropractor: _____ Did they take X-rays? Y/N

What are your health goals?

☐ Symptom relief and preventing its return
☐ 100% optimum health and wellbeing on every level available to me

_____

MAJOR HEALTH CONCERN #1 – PLEASE FILL IN ALL AREAS: IF NOT APPLICABLE PUT "N/A"

What condition brought you to our office? _____
_____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/10
When did it start? _____ How? _____
Is it…
☐ Getting better ☐ Getting worse ☐ Staying the same
How many times a week do you feel the pain? _____
What percentage of the day do you feel pain? 25% 50% 75% 100%
How would you describe the problem? _____
Are you taking medication for this condition? Y/N (circle)
If yes, which medication? _____ Dose: _____
Do you have family history of this same condition? Y/N (circle)
Have you seen anyone else for this condition? Y/N (circle) Who? _____
Any significant family medical conditions/history? Y/N_____
Describe the physical nature of your occupation_____
Do you smoke? Y/N (circle)
Do you consume alcoholic beverages? Y/N (circle) If yes, how many/week? _____
Please list ANY medications you are currently taking: _____
_____

Have you ever been in a car accident? Y/N (circle) If yes, when? _____

YOUR HEALTH HISTORY:

Please check all that you have experienced in your ***lifetime***:

☐Headaches	☐Migraines	☐Dizziness	☐Sinus Problems
☐Depression	☐Neck Pain	☐Shoulder Pain	☐Ringing in Ears
☐Ear infections	☐Allergies	☐Upper Back Pain	☐Hand/Wrist Pain
☐Gout	☐Chest Pain	☐Fatigue	☐Mid back Pain
☐Rib Pain	☐Jaw Problems	☐Heart Disease	☐Low Back Pain
☐Ankle/Knee Pain	☐Heartburn	☐Diarrhea	☐Hip Pain
☐Cancer	☐Constipation	☐Diabetes	☐Menstrual Cramps
☐High Blood Pressure	☐Difficulty Breathing	☐Stomach Pain	☐Asthma
☐High Cholesterol	☐Difficulty Sleeping	☐Anxiety	☐Decreased Energy
☐Arthritis	☐Thyroid Condition	☐Stroke	☐Jaundice
☐Carpal Tunnel Syndrome	☐Hot Flashes	☐Ulcers	☐Other

Please fill out the following information on the *above* most serious conditions; or any other condition that you may have (excluding "Major Health Concern" on page 1):

Condition 1: _____
On a scale of 1-10 (10 being severe), how bad is the problem? _____/10
When did it start? _____ How? _____
It is
☐ Getting better ☐ Getting worse ☐ Staying the same
How many times a week do you feel the pain?_____
What percentage of the day do you feel pain? 25% 50% 75% 100%
How would you describe the problem? _____
Are you taking medication for this condition? Y/N
If yes, which medication? _____ Dose: _____

Condition 2: _____
On a scale of 1-10 (10 being severe), how bad is the problem? _____/10
When did it start? _____ How? _____
Is it:
☐ Getting better ☐ Getting worse ☐ Staying the same
How many times a week do you feel the pain?_____
What percentage of the day do you feel pain? 25% 50% 75% 100%
How would you describe the problem? _____
Are you taking medication for this condition? Y/N
If yes, which medication? _____ Dose: _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and that Rivergrove Chiropractic has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____ _____
Signature Date

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM - L

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscle ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are cause, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20___.

_____ **_____**

Patient Signature (Legal Guardian) **Witness of Signature**

Name: _____ **Name: _____**

(please print) **(please print)**