Information reviewed with patient:

Dr. Initials_____

# Brisbin Family Chiropractic

Today's Date_____

## PATIENT INFORMATION

Patient Name_____

Address _____

City _____ Postal Code_____

Phone #_____

Email _____

☐ I do not want to be contacted through email

Gender _____ Age ___ Date of Birth _____

Employer/School _____

Occupation _____

**Alberta Health Care #** _____

Spouse's Name_____

Name and Age of Children_____

_____

**IN CASE OF EMERGENCY, CONTACT**

Name_____

Relationship_____

Contact Number _____

**Who may we thank for referring you?** _____

Have you ever received chiropractic care? ☐ Yes ☐ No

If yes, who and approximately when? _____

## HOW CAN WE HELP YOU?

What brings you in today? ☐ Wellness Checkup ☐ Specific concern

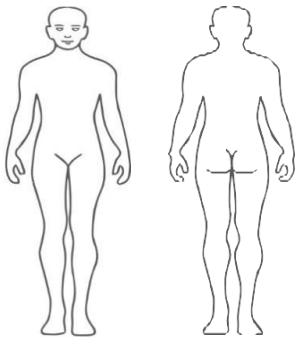
If you are already experiencing symptoms, what are they? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check all that apply)

| | |
|---|---|
| ☐ Numbness | ☐ Sharp |
| ☐ Tingling | ☐ Shooting |
| ☐ Stiffness | ☐ Burning |
| ☐ Dull | ☐ Throbbing |
| ☐ Aching | ☐ Stabbing |
| ☐ Cramping | ☐ Swelling |
| ☐ Nagging | ☐ Other |

Is this related to a Motor Vehicle Accident **in the last 10 days**? ☐ No ☐ Yes, date of accident _____

Is this a work-related injury (WCB claim)? ☐ No ☐ Yes

Have you received spinal x-rays in the last 2 years? ☐ No ☐ Yes

Is there a chance you are pregnant? ☐ No ☐ Yes

Do you wear orthotics or special shoe inserts? ☐ No ☐ Yes

## IMPACT OF YOUR SYMPTOMS

**How are these symptoms/conditions interfering with your life? (check where appropriate)**

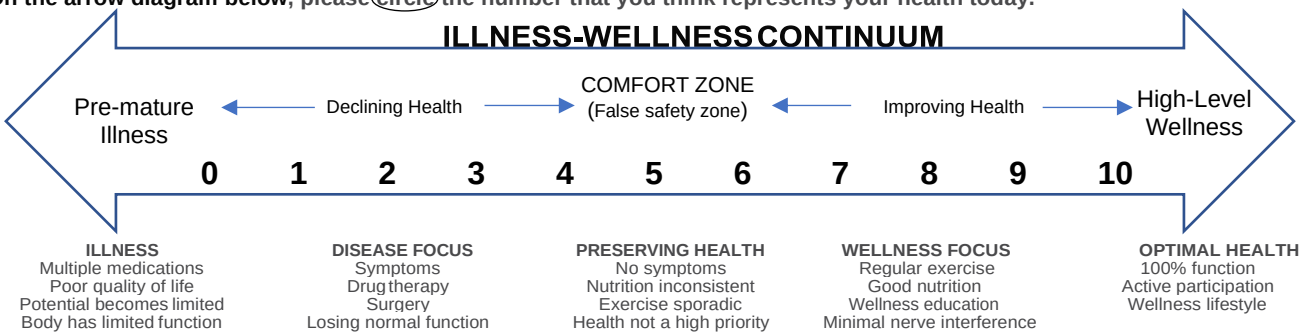
| | No Effect | Mild Effect | Moderate Effect | Severe Effect | | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|---|---|---|---|---|
| Work | ☐ | ☐ | ☐ | ☐ | Energy | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ | Attitude | ☐ | ☐ | ☐ | ☐ |
| Recreation | ☐ | ☐ | ☐ | ☐ | Patience | ☐ | ☐ | ☐ | ☐ |
| Relationships | ☐ | ☐ | ☐ | ☐ | Productivity | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ | Creativity | ☐ | ☐ | ☐ | ☐ |
| Self care | ☐ | ☐ | ☐ | ☐ | Other_____ | ☐ | ☐ | ☐ | ☐ |

**As a result of chiropractic care, I would like to achieve: (check all that apply)**

☐ Symptom relief ☐ Correction of underlying cause ☐ Prevention of future problems ☐ General wellness

## PATIENT WELLNESS ASSESSMENT

**Our health is constantly changing based on the health decisions we make on a daily basis.**
**On the arrow diagram below, please circle the number that you think represents your health today.**




| ILLNESS | DISEASE FOCUS | PRESERVING HEALTH | WELLNESS FOCUS | OPTIMAL HEALTH |
|---|---|---|---|---|
| Multiple medications | Symptoms | No symptoms | Regular exercise | 100% function |
| Poor quality of life | Drug therapy | Nutrition inconsistent | Good nutrition | Active participation |
| Potential becomes limited | Surgery | Exercise sporadic | Wellness education | Wellness lifestyle |
| Body has limited function | Losing normal function | Health not a high priority | Minimal nerve interference | |

**What are your health goals? (please describe short and long term goals below)**

SHORT TERM (Decreased pain / Injury recovery / Increased mobility / Decreased stiffness / Other _____)

LONG TERM (Active lifestyle / Less sick days / More energy / More strength / Other _____)

## TRAUMA HISTORY (Previous injuries and accidents can affect how our body can regain its strength.)

**Have you ever had any of the following? (check all that apply and describe/date)**

- ☐ Head Injuries _____ ☐ Concussions _____
- ☐ Motor Vehicle Accidents _____
- ☐ Broken Bones _____
- ☐ Surgeries _____
- ☐ Heart Attacks _____ ☐ Strokes _____

**Is there a family history of (check all that apply)**

☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Diabetes

Allergies, medications, supplements (please list):_____
_____

## LIFESTYLE STRESSES (What we do on a daily basis affects how quickly our body can adapt and heal.)

### Physical Stressors

What do you spend most of your day doing? (check all that apply)

- ☐ Sitting
- ☐ Standing
- ☐ Lifting
- ☐ Driving
- ☐ Walking

How often do you exercise?

- ☐ Daily
- ☐ 2-3x/week
- ☐ 1x/week
- ☐ <1x/week
- ☐ Never

Rate your posture

- ☐ Excellent
- ☐ Good but needs work
- ☐ Poor

Rate your physical stress (1=low,10=high)
1----------5----------10

### Chemical Stressors

Do you smoke?

- ☐ Yes
- ☐ No

My alcohol consumption is:

- ☐ Never
- ☐ Rarely
- ☐ Weekly
- ☐ Daily

My caffeine intake is:

- ☐ Low
- ☐ Moderate
- ☐ High

My diet is:

- ☐ Healthy
- ☐ Ok
- ☐ Poor

Rate your chemical stress (1=low,10=high)
1----------5----------10

### Emotional Stressors

My mental stresses include: (check all)

- ☐ Work
- ☐ Home
- ☐ School
- ☐ Family
- ☐ Finances
- ☐ Health
- ☐ Children
- ☐ Relationships

Rate your sleep

- ☐ Great
- ☐ Ok
- ☐ Poor
- ☐ Awful

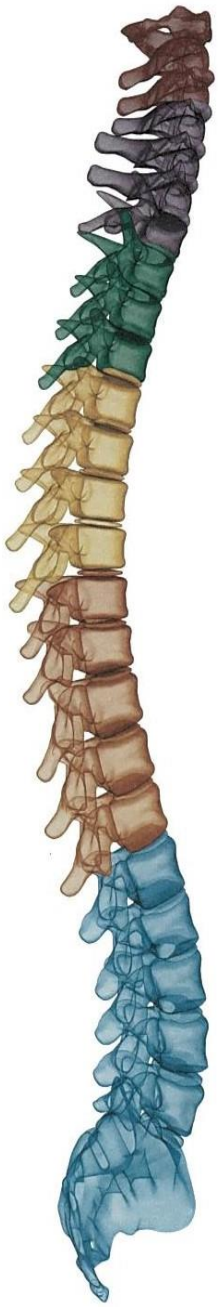
How many hours per week do you work?

_____

Rate your emotional stress (1=low,10=high)
1----------5----------10

# Patient Review of Systems

*Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present*



| REGIONS | FUNCTIONS | Past | Present | SYMPTOMS | Past | Present | |
|---|---|---|---|---|---|---|---|
| **Cervical** | • Autonomic Nervous system<br>• ENT System<br>• Vision, Balance & Coordination<br>• Speech<br>• Immune System<br>• Digestive System<br>• Nerve Supply to Shoulders, Arms & Hands<br>• Metabolism | ☐ | ☐ | Ear & Sinus Infections | ☐ | ☐ | Epilepsy & Seizures |
| | | ☐ | ☐ | Allergies & Congestion | ☐ | ☐ | Sensory & Spectrum |
| | | ☐ | ☐ | Immune Deficiency | ☐ | ☐ | ADD / ADHD |
| | | ☐ | ☐ | Headaches & Migraines | ☐ | ☐ | Focus & Memory Issues |
| | | ☐ | ☐ | Vertigo & Dizziness | ☐ | ☐ | Anxiety & Stress |
| | | ☐ | ☐ | Sore Throat & Strep | ☐ | ☐ | Balance & Coordination |
| | | ☐ | ☐ | Swollen Tonsils & Adenoids | ☐ | ☐ | Speech Issues |
| | | ☐ | ☐ | Vision & Hearing Issues | ☐ | ☐ | TMJ / Jaw Pain |
| | | ☐ | ☐ | Low Energy & Fatigue | ☐ | ☐ | Stiff Neck & Shoulders |
| | | ☐ | ☐ | Difficulty Sleeping | ☐ | ☐ | Depression |
| | | ☐ | ☐ | Pain, Numbness & Tingling in Arms to Hands | ☐ | ☐ | High Blood Pressure |
| | | | | | ☐ | ☐ | Poor Metabolism |
| **Upper Thoracic** | • Upper G.I.<br>• Respiratory Function<br>• Cardiac Function | ☐ | ☐ | Reflux / GERD | ☐ | ☐ | Bronchitis & Pneumonia |
| | | ☐ | ☐ | Chronic Colds & Coughs | ☐ | ☐ | Functional Heart Conditions |
| | | ☐ | ☐ | Asthma | ☐ | ☐ | Upper back discomfort |
| **Mid Thoracic** | • Major Digestive Center<br>• Detox & Immunity | ☐ | ☐ | Gallbladder Pain / Issues | ☐ | ☐ | Indigestion & Heartburn |
| | | ☐ | ☐ | Jaundice | ☐ | ☐ | Stomach Pains & Ulcers |
| | | ☐ | ☐ | Fever | ☐ | ☐ | Blood Sugar Problems |
| **Lower Thoracic** | • Stress Response<br>• Filtration & Elimination<br>• Gut & Digestion<br>• Hormonal Control | ☐ | ☐ | Behavior Issues | ☐ | ☐ | Allergies & Eczema |
| | | ☐ | ☐ | Hyperactivity | ☐ | ☐ | Skin Conditions / Rash |
| | | ☐ | ☐ | Chronic Fatigue | ☐ | ☐ | Kidney Problems |
| | | ☐ | ☐ | Chronic Stress | ☐ | ☐ | Gas Pain & Bloating |
| **Lumbar, Sacrum & Pelvis** | • Lower G.I. (Absorption & Motility)<br>• Gut-Immune System<br>• Major Hormonal Control | ☐ | ☐ | Constipation | ☐ | ☐ | Sciatica & Radiating Pain |
| | | ☐ | ☐ | Crohn's, Colitis & IBS | ☐ | ☐ | Lumbopelvic / SI Joint Pain |
| | | ☐ | ☐ | Diarrhea | ☐ | ☐ | Hamstring Tightness |
| | | ☐ | ☐ | Bladder & Urinary Issues | ☐ | ☐ | Disc Degeneration |
| | | ☐ | ☐ | Cramps & Menstrual Issues | ☐ | ☐ | Leg Weakness |
| | | ☐ | ☐ | Cysts & Endometriosis | ☐ | ☐ | Leg Cramps / Spasms |
| | | ☐ | ☐ | Infertility | ☐ | ☐ | Poor Circulation & Cold Feet |
| | | ☐ | ☐ | Impotency | ☐ | ☐ | Knee, Ankle & Foot Pain |
| | | ☐ | ☐ | Hemorrhoids | ☐ | ☐ | Weak Ankles & Arches |
| | | ☐ | ☐ | Tailbone Pain | ☐ | ☐ | Lower Back Pain |

# 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 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 the 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 with only last 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 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 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 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.

_____

Name (Please Print)

_____ Date:_____20_____

Signature of patient (or legal guardian)

_____ Date:_____20_____

Signature of Chiropractor