



#16, 15508 87 Avenue NW
Edmonton, AB T5R 4G5
(780)705-3556

Confidential Health History

Name Birthdate: / / (Age:)
Address DD/MM/YYYY
City Edmonton Other: Sex: Female Male Other:
Postal Code Occupation:
Mobile No. () - Employer:
Home No. () - Alberta Health #:
Email:

Note: your email is used for appointment reminders, receipts, billing and booking communication.
Select to opt out.

*To stay up to date on our promotions, discounts, or office events, follow us on Facebook and Instagram (@livewellfamilychiro)

Are you currently a student? Yes No
Is there a chance you could be pregnant? Yes No
Is this related to a car accident in the past 10 days? Yes No
Is this related to a workplace injury (WCB Claim) Yes No

Who can we thank for referring you to our office?
How do you know them?
If you were not referred by a friend or family, how did you hear about our office?
Have you been to a Chiropractor before? Yes No
If Yes, Who When was your last visit?
Do you wear orthotics or special shoe inserts? Yes No If yes, how old are they?

Emergency Contact: Phone Number:

Why This Form is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness. 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 present and future health.

Systems Review

Please check any symptoms that are currently affecting your quality of life, even if you do not believe them to be Chiropractic related.

<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Constipation	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Frequent Colds/Flus
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bloating/Gas	<input type="checkbox"/> Arthritis/Degeneration
<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Cough	<input type="checkbox"/> Sciatic Pain	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Allergy/Sinus Problems	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cramping in legs	<input type="checkbox"/> Loss of bladder control or bladder retention
<input type="checkbox"/> Seizures	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Loss of bowel control
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Foot Pain/Numbness	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Arm/Shoulder Pain	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Bladder Control	<input type="checkbox"/> Numb or tingling in buttox, groin or saddle area
<input type="checkbox"/> ADD/ADHD		<input type="checkbox"/> Sexual Dysfunction	<input type="checkbox"/> Pain that wakes you up at night
<input type="checkbox"/> Neck Pain		<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Unexplained weight loss

WOMEN ONLY

<input type="checkbox"/> Painful Menstration	<input type="checkbox"/> Irregular Cycles	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Infertility
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> PMS	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Early Onset Menopause
	_____ # of pregnancies	_____ # of births	
Have you ever Experienced?	<input type="checkbox"/> C-Section	<input type="checkbox"/> Epidural	<input type="checkbox"/> Induction
	<input type="checkbox"/> Forceps	<input type="checkbox"/> Vacuum Suction	<input type="checkbox"/> Breech Baby

Surgeries:

Date:	Type and Reason for Surgery
_____	_____
_____	_____

Medications:

Reason for Taking:	_____
_____	_____
_____	_____

Supplements

Reason for Taking:	_____
_____	_____
_____	_____

Is there a family history of: (circle all that apply)

Heart disease Stroke Cancer Diabetes Thyroid Problems Other: _____

CCPA CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

Patient Name (print)

Patient/Guardian Signature

Date

Chiropractor Signature