SYDNEY CHIROPRACTIC DR. DAVID DUNN

PERSONAL HISTORY

Name: ______________________ Address: ______________________

City: ______________________ Province: __________ Postal Code: __________

Home Phone: ______________________ Birthdate: __________ Age: ______

Cell Phone: ______________________ Gender: Birth: _____ Current: _____ Pronouns: __________

Height: ______ Weight: ______ Business Employer: ______________ Business Phone: ______________

Type of Work You Do: ______________________ E-mail: ______________________

Emergency Contact: ______________ Phone Number: ______________ Relationship: ______________

Who may we thank for referring you to this office? ______________________

Would you like to receive our monthly e-mail newsletter: ☐No ☐Yes

How did you hear about our office ☐TV ☐Radio ☐Internet ☐Flyers ☐Newspaper
☐Family/Friend ☐Facebook ☐Google ☐Other

CURRENT HEALTH CONDITION

Current Complaint(s): ______________________

When did this condition begin?: ______________________ Has it occurred before : ☐Yes ☐No

If this condition has occurred before, when?: ______________________

What caused it? ☐Work Injury ☐Car Accident ☐Home Injury ☐Fall ☐I don't know

If you know, describe what caused it: ______________________

If there was an accident or work injury, please give the date: ______________________

Have you seen other doctors for this condition? ☐No ☐Yes Dr. ______________________

Type of Treatment? ______________________ Result of treatment ______________________

What aggravates your condition? ☐Sitting ☐Standing ☐Bending ☐Lifting ☐Walking
☐Lying Down ☐Cold ☐Exercise ☐Other ______________

What relieves your condition? ☐Bed Rest ☐Ice ☐Heat ☐Massage ☐Medication
☐Chiropractic ☐Exercise ☐Other ______________

Is the problem: ☐Constant ☐Comes/Goes ☐Getting worse ☐Getting better

How does it feel? ☐Sharp ☐Dull ☐Ache ☐Pins and Needles ☐Numb ☐Burning

Other description on how it feels: ______________________

____

____

____

____

____

Place an X on the grade to indicate the **severity** of your pain:

LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:

Your ability to work? ______

Your ability to enjoy your family or your social time? ______

Your ability to enjoy your hobbies or sports? ______

At its worst, how **old** does this problem make you feel? ______

If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No

Drugs you are now taking: ☐ Painkillers ☐ Muscle Relaxers ☐ Arthritis ☐ Blood Pressure
☐ Insulin ☐ Anit-depressants ☐ Cholesterol ☐ Blood Thinners
☐ Heart Pills ☐ Osteoporosis ☐ Light Sensitive ☐ Other: ______

Do you suffer from any other conditions than the one you are now consulting us for? ______

Have you had X-rays, CT scans, or an MRI of your problem area taken before? ☐ Yes ☐ No

If yes, what test and of what area? ______ When? ______

PAST HEALTH HISTORY

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other: ______

Previous: ☐ Childhood Traumas? ______ ☐ Sports Injuries? ______

Hospitalization? (other than above): ______

Previous Chiropractic Care? ☐ No ☐ Yes, Doctor's Name: ______

Approximate Date of Last Visit: ______

FAMILY HEALTH HISTORY

Name and address of Family Physician: ______

Please indicate any health issues that are present in your family:

Parents: ______

Siblings: ______

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? ______

Have your children ever had a spinal check-up? ☐ No ☐ Yes, where and when? ______

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 you have had in the past six months:

Nervous System

- ☐ Nervous
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Depression
- ☐ Fainting
- ☐ Falling
- ☐ Balance Disturbances
- ☐ Convulsions
- ☐ Tingling In Hands/Fingers
- ☐ Tingling In Feet/Toes
- ☐ Numbness/Tingling Elsewhere

Musculo-Skeletal

- ☐ General Stiffness
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Pain Between Shoulders
- ☐ Headaches
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Foot/Feet Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing
- ☐ Wrist Pain

General

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss Of Sleep
- ☐ Fever
- ☐ Significant Stress
- ☐ Weight Trouble

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Colitis
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool

Male / Female

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate Problems
- ☐ Sexual Dysfunction
- ☐ Pregnancy/Birth

Genito-Urinary

- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Stones

Females Only
When was your last period?

____

Are you pregnant?

__Yes __No __Not Sure

Dietary Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

- ☐ No
- ☐ Yes, What? ______________

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Low

Do you take any vitamins or supplements?

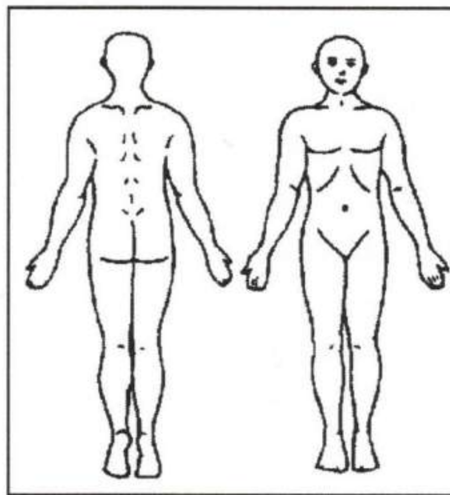
- ☐ No
- ☐ Yes

If yes, please list: ______________

____

____

____



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

Check any of the following diseases you have had:

- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Pneumonia
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lupus
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema
- ☐ Aortic Aneurysm
- ☐ Cancer
  Past / Present

If Yes, what type and when

____

____

____

____

"Helping Cape Bretoners live healthier lives since 1978".

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 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 will last only 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 also 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