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Chiropractic Care Initial Consultation

Our Mission To make Truro and Colchester County the healthiest communities on the planet... and it begins with YOU!

Patient Information *Please Print*

Name ______________________ Consultation Date *D/M/Y* ___/___/___

Age _____ D.O.B. *D/M/Y* ___/___/___ Gender *M/F* _____ Marital Status *Single/Married/Divorced/Widowed* _______

Children *None/Number of Children* _______ Children *Names/Ages/Gender* ______________________

____

____

Occupation ______________________ Family Doctor ______________________

Address ______________________ Town ______________________ Postal Code __________

Phone *Home* ______________________ *Work* ______________________ *Cell* ______________________

Email *We use email for appointment reminders & primary method of contact* ______________________

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

Health Profile

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way that we can make you or your family more comfortable. To help us serve you better, please complete the following information.

"Subluxations" or spinal misalignments are a condition of the spine that chiropractors are trained to detect. Research is now showing that dysfunction within the body can be the *result* of these subluxations. Often other symptoms are seen years before pain is noticed. It is for this reason we ask a wide variety of questions regarding your health. On a daily basis we experience physical, chemical and emotional stress that can lead to subluxation. Help us identify these.

Physical Stress *(falls, accidents, work posture, sport participation, etc)*

What is your current weight? ______________________ What is your goal weight? ______________________

Have you ever had a concussion? ○ Yes ○ No Have you ever broken any bones? ○ Yes ○ No

Please list any health conditions you have been diagnosed with: ______________________

____

Have you had x-rays of the spine done in the last 2 years? ○ Yes ○ No If yes, please explain ________

____

Do you wear orthotics? ○ Yes ○ No If yes, how old ______________________

Have you had any surgery? *Please list all surgeries including childhood.*

1. *Type* ______________ *Date D/M/Y* ___/___/___ 2. *Type* ______________ *Date D/M/Y* ___/___/___
3. *Type* ______________ *Date D/M/Y* ___/___/___ 4. *Type* ______________ *Date D/M/Y* ___/___/___

Have you had any accidents and/or injuries? *Please list all injuries including childhood.*

1. *Type* ______________ *Date D/M/Y* ___/___/___ 2. *Type* ______________ *Date D/M/Y* ___/___/___
3. *Type* ______________ *Date D/M/Y* ___/___/___ 4. *Type* ______________ *Date D/M/Y* ___/___/___

Chemical Stress *(smoking, unhealthy foods, missed meals, don't drink enough water, alcohol, drugs, etc)*

Do you smoke? ○ Yes ○ No If yes, how many per day ____________

How much alcohol do you drink per day? ____________

Are you currently participating in any medical research studies? ○ Yes ○ No ____________

Please list any medications you are taking and for what condition

1. ____________ *Condition* ____________ 2. ____________ *Condition* ____________
3. ____________ *Condition* ____________ 4. ____________ *Condition* ____________

Please list all supplements, minerals, vitamins and what brand they are

1. ____________ *Brand* ____________ 2. ____________ *Brand* ____________
3. ____________ *Brand* ____________ 4. ____________ *Brand* ____________

Emotional Stress *(self-esteem, relationships, work, etc)*

Sleep *Please rate your stress level by marking an X in the appropriate circle.*

No stress — *Extreme stress*

1 2 3 4 5 6 7 8 9 10

Mindset

No stress — *Extreme stress*

1 2 3 4 5 6 7 8 9 10

Personal relationships

No stress — *Extreme stress*

1 2 3 4 5 6 7 8 9 10

Occupational

No stress — *Extreme stress*

1 2 3 4 5 6 7 8 9 10

Finances

No stress — *Extreme stress*

1 2 3 4 5 6 7 8 9 10

Consultation

Reason for seeking Chiropractic care? ____________

____

Is this problem: ○ Occasional ○ Frequent ○ Constant ○ Intermittent ○ Other ____________

When did the problem begin? ____________

Does the pain radiate? ○ Yes ○ No If yes, where? ____________

____

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Consultation *(cont.)*

What makes it better? ______

What makes it worse? ______

Is this problem worse during a certain time of day? ○ Yes ○ No If yes, when? ______

Other health professionals seen for this condition ______

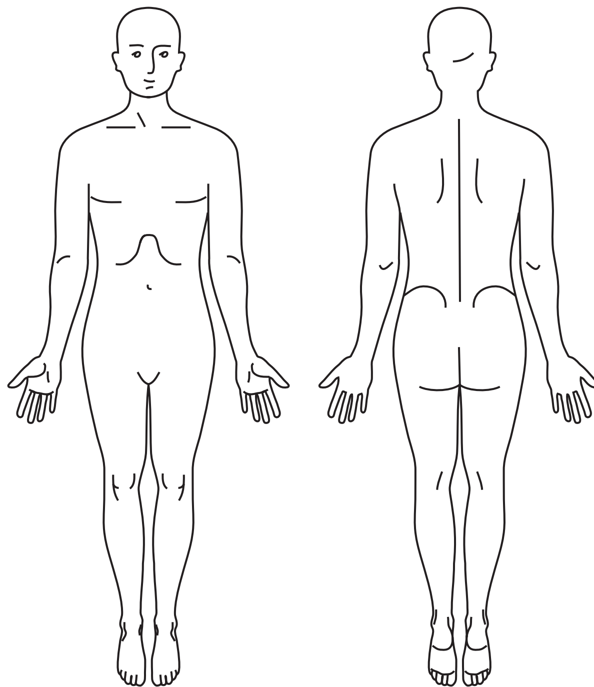
Results with treatment ______

Is this condition interfering with your:

○ Work ○ Sleep ○ Leisure ○ Attitude ○ Hobbies ○ Other ______

Other health problems or conditions? ______

Please outline on the diagram the area of your discomfort.



Family Health History

Please note any health problems (i.e. cancer, hereditary conditions, diabetes, heart disease, etc) that are present in:

Parents ______

Siblings ______

Does any member of your family suffer from the same condition? ○ Yes ○ No If yes, whom? ______

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

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General Health History

Below is a list of diseases which 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.

Please mark an X in the circles that apply to you in the PAST 6 MONTHS:

Nervous System

- Anxiety
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

Musculo-Skeletal

- Low Back Pain
- Gas/Bloating after meals
- Pain between Shoulders
- Heartburn
- Neck Pain
- Black/Bloody Stool
- Arm Pain
- Colitis
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

Gastro-Intestinal

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

C-V-R

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

EENT

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

General

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

Male/Female

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction

Genito-Urinary

- Bladder Trouble
- Discoloured Urine
- Painful/Excessive Urination

Past Health History

Please list any hospitalizations and their reason (*Other than surgeries listed in page 1).* ____________________

____

____

____

Any previous chiropractic care? ○ Yes ○ No

If yes, what is the Doctor's name ____________________ Approximate date of last visit *D/M/Y* ___/___/___

Be Fit. Eat Right. Think Well.

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Informed Consent

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a. While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy techniques;
b. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest patients may be consulting medical doctors and chiropractors when they are in the early stages of stroke. In essence, there is a stroke already in progress. However, you are being informed about this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
c. There are reported rare cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
d. There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.
I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.
I intend this consent to apply to all my present and future chiropractic care.

Date ___/___/___

Patient Name ______________________________ **Patient Signature** ______________________
or Legal Guardian *Please Print* or Legal Guardian

Witness Name ______________________________ **Witness Signature** ______________________
or Legal Guardian *Please Print* or Legal Guardian

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