Barrhaven FAMILY CHIROPRACTIC
Experience the NeuroStructural Difference

605 Longfields Dr.
Nepean, K2J 6T7
613-823-7900
www.barrhavenchiropractic.ca

FULL NAME: _____ DATE:_____

*PLEASE PRINT CLEARLY

Address:		City/Province/Postal Code:	
*Preferred Number	Home Phone:	Work :	Cell Phone:
Would you like to be added to our Text Message Reminders	Y ☐ N ☐		
Birth date (dd/mm/yyyy):		Age:	Marital Status: M ☐ W ☐ D ☐ S ☐
E-mail address:			
Your Employer:		Occupation:	
Spouse's Name:		Spouse's Occupation:	
Children's Names, Gender, and Ages:			

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

Have you ever been to a chiropractor before? _____ **How was your experience?** _____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Reason for seeking chiropractic care:

_____

_____

When did you FIRST start to experience this problem,_____

How would you describe your symptoms? Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

Which activities aggravate your condition?

_____

What have you done for this condition? Was it of benefit?

_____

Are you under the care of any other practitioners? (Medical, Chiropractic, RMT, Physio. or others? Yes □ No □

Name:	Discipline (DC, MD, Dentist, RMT, PT etc)
What are they treating you for?	Has it helped?

General Health History

Current Medicines and Supplements

Current medications/drugs (prescription/non-prescription) and why:

_____

List all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

Past Health History

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, since chiropractic adjustments affect your nervous system and your nervous system controls and coordinates ***every*** function of your body, the following questions must be answered carefully for us to have a complete understanding of your unique situation.

**Please indicate with a C (Currently) or a P (Past) or C,P (Current and Past)

_____ Fatigue	_____ Neck Pain / Stiffness	_____ Loss of Balance	_____ Fever
_____ Sleeping Problems	_____ Shoulder Pain	_____ Earaches	_____ Cold Sweats
_____ Frequent Colds	_____ Mid Back Pain	_____ Ringing in ears	_____ Lights Bother Eyes
_____ Allergies	_____ Low Back Pain	_____ Irritable	_____ Skin Conditions
_____ Asthma	_____ Hip Pain	_____ Depression	_____ Urinary Problems
_____ Digestion Problems	_____ Joint Pain	_____ Nervousness	_____ Mood Swings
_____ Weakness	_____ Chest Pain	_____ Tension	_____ Brain Fog
_____ Dizziness	_____ Heart Problems	_____ Ulcers	_____ Difficulty Focusing
_____ Nausea	_____ Pins/Needles in legs/feet	_____ Pins/Needles In Arms	_____ Unexplained weight loss/gain
_____ Headaches	_____ Leg/Foot Pain	_____ Numbness in fingers	_____ Numbness in Toes
_____ Migraines	_____ Fainting	_____ Arm/Hand Pain	_____ Cold Hands/Feet

***Females Only ***	**Yes**	**No**		**Yes**	**No**
Painful Menstruation	□	□	Passed Menopause	□	□
Excessive Flow	□	□	Birth Control Pill	□	□
Irregular	□	□	Intra-uterine device	□	□
Cramps/backache	□	□	Hysterectomy	□	□
Abnormal discharge	□	□	Tubal Ligation	□	□

Date of last period: _____

(Women of Child bearing age only)

I certify that, to the best of my knowledge, I am not pregnant and I may have x-rays taken (if necessary and agreed upon)

Initials _____

I Consent to have have x-rays taken (if necessary and agreed upon) **Initials**_____

YOUR HEALTH GOALS

How is your current condition affecting your life?

_____

What are your desired health outcome(s)? This will help us to understand what your vision is for your health.

□ Improvement in function □ Pain reduction □ Improved quality of life □ Manage my crisis
□ Symptom management □ Wellness □ Healthier immune system □ Stress reduction

Other:

_____

Potential Causes of Structural Shifts

You literally live your life through your nerve system. The stress you have encountered in your life will help us understand the demands you have placed on your body. Please check off if you have ever experienced this stress in your life. This will serve us better in understanding how you will respond to your chiropractic care.

Physical Stress

- □ Birth Trauma
- □ Slips / Falls
- □ Car Accidents
- □ Sports Injuries
- □ Physical Abuse
- □ Work Injuries
- □ Poor Posture
- □ Sitting on your wallet for years
- □ Sleeping Position – Stomach
- □ Extensive Computer Work
- □ Heavy Purse/Backpack
- □ Heavy Lifting/Bending

Emotional Stress

- □ Relationships
- □ Work
- □ Children
- □ Money/Bills
- □ Homework
- □ Exams
- □ Fast-Paced Life
- □ Bottled-up Feelings
- □ Quick Tempered
- □ Verbal Abuse
- □ Perfectionist

Chemical Stress

- □ Environment (Pollution)
- □ Smoker or second hand smoke

- □ Poor Diet
- □ Caffeine – amount? _____

- □ Excessive Sugar
- □ Artificial Sweeteners
- □ Prescription Drugs
- □ Over-the-counter Drugs
- □ Recreational Drugs

Is there anything else which may help us to better understand you and/or your situation?

_____

Do you have insurance for chiropractic care? YES □ NO □ If yes, with whom and how much: _____

Do you consent for us to verify your visits with your insurance provider, if they contact us? YES □ NO □

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients of benefits and risks including sprain/strain, rib fracture, disc herniations, and with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in 25-50 million. Tests, with or without x-rays will be performed on you to minimize these risks to yourself. Chiropractic is considered to be one of the safest and most effective forms of corrective care for neck conditions. If you have any questions about this, please ask your chiropractor.

Signature_____ **Date Signed** _____

Doctor's Use Only:

_____

_____

Exam consent given : _____