NEW PATIENT FORM

In order to provide you the best possible care, please complete this form as thoroughly as possible. All information is strictly confidential. The doctor will review your history and with your consent, do a thorough examination to determine if chiropractic care will best benefit you.

Date: _____

PATIENT DATA

Full Name: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ Prov: _____ Postal Code: _____

Telephone: *(home)* ___-___-_____ *(work)* ___-___-_____ Birthdate: _____

Age: _____ Occupation: _____

Email Address: _____ Marital Status: ☐ Single ☐ Married ☐ Separated

Medical Doctor: _____ Have you ever received Chiropractic care? ☐ YES ☐ NO

If yes: By who: _____

How did you find out about our clinic?

_____

Have you ever or do you presently suffer from any of the following symptoms?

☐ Headaches or migraines	☐ Ears ring/buzz	☐ Stiff/painful neck	☐ Dizziness	☐ Vision changes/loss	☐ Loss of balance	☐ Fainting	☐ High/low blood pressure
☐ Heart/lung troubles	☐ Stroke	☐ Asthma	☐ Digestive disorders	☐ Menstrual problems	☐ Kidney disease	☐ Liver disease	☐ Sexual dysfunction
☐ Fatigue	☐ Sleep problems	☐ Depression	☐ Mood swings	☐ Chronic worry	☐ Poor concentration	☐ Seizures	☐ Nose bleeds
☐ Varicose veins	☐ Sinus problems	☐ Frequent colds	☐ Osteoporosis	☐ Cancer	☐ MS	☐ Diabetes	☐ Skin disorders
☐ Numbness or pins/needles in legs	☐ Allergies	☐ Arthritis	☐ Cold feet/hands	☐ Thyroid disorder	☐ Chest pains	☐ Bed wetting	☐ Respiratory issues
☐ Weight loss/gain	☐ Muscle weakness	☐ Bruise easily	☐ Difficulty breathing	☐ Bowel difficulties	☐ Shortness of breath	☐ Pain over heart	☐ Excessive/loss appetite

WOMEN ONLY BELOW:

Menstrual flow ☐ Regular ☐ Irregular	☐ Hot flashes	☐ Lumps in breast	☐ Menopause	☐ Vaginal Discharge	Are you Pregnant? ☐ Yes ☐ No	Last PAP test ☐ Normal ☐ Abnormal	Last mammogram ☐ Normal ☐ Abnormal

Are you pregnant? ☐ Yes ☐ No How many children do you have? Birth control method?

If yes, how many months? _____ _____ _____

Give a brief description of the problem you are currently experiencing

_____

_____

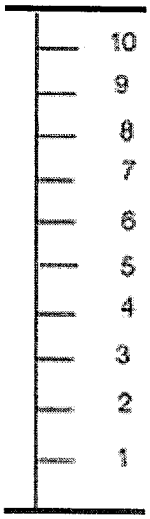
_____

How long have you had this condition? _____ Is it getting worse? ☐ YES ☐ NO

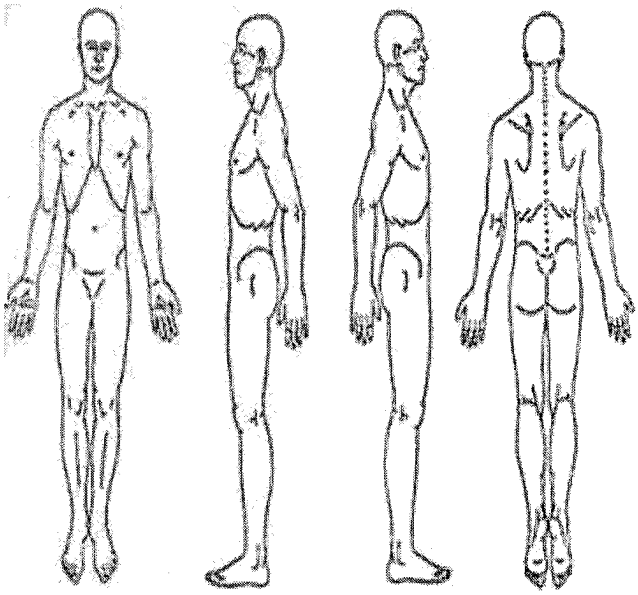
Does it bother you (*check appropriate box*) ☐ work ☐ sleep ☐ other _____

What seemed to be the initial cause? _____

Please place a mark at the level of your pain on the scale below



Please mark your area(s) of pain on the figure below



Have you:	YES	NO	If yes, explain briefly
Been hospitalized in the last 5 years?	☐	☐	_____
Had any mental disorders?	☐	☐	_____
Had any broken bones?	☐	☐	_____
Had any sprains or strains?	☐	☐	_____
Ever used orthotics?	☐	☐	_____
Taken any minerals, herbs, or vitamins?	☐	☐	_____
How is most of your day spent?	☐ Sitting	☐ Standing	☐ Other
How old is your mattress?			_____
When was your last physical exam?			_____

FAMILY HISTORY: *If any blood relatives have had any of the following, please check box.*

☐ Alcoholism ☐ Anemia ☐ Arteriosclerosis ☐ Arthritis ☐ Asthma ☐ Bleed easily ☐ Cancer
☐ Diabetes ☐ Emphysema ☐ Epilepsy ☐ Glaucoma ☐ Heart Disease ☐ High Blood Pressure
☐ High Cholesterol ☐ Multiple Sclerosis ☐ Osteoporosis ☐ Stroke ☐ Thyroid Disease

YOUR WELLNESS HISTORY

YOUR GOALS

On a scale of 1 to 10 (1 = **none**, 10 = **extreme**), describe your emotional/psychological/lifestyle stress levels:
Scale = ____ Occupational stress: _____
Scale = ____ Personal stress: _____

On a scale of 1 to 10 (1 = **poor**, 10 = **excellent**), describe your habits and condition as it relates to:
Eating habits ____ Exercise habits _____ Sleep _____ General Health _____
Wellness Lifestyle _____ Mind-set_____

At our office, we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness in the spaces provided:

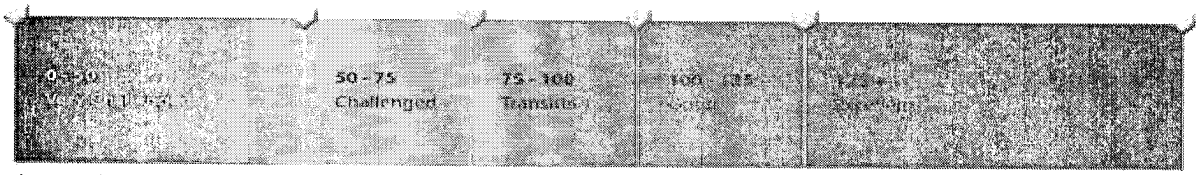
Physical Goals:	*Nutritional/Biochemical Goals:*	*Psychological Goals:*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all that are relevant.

Do you:
- ☐ Water – Drink ½ your body weight in ounces
- ☐ Exercise regularly
- ☐ Take vitamins or supplements

Would you like to know more about:
- ☐ Proper nutrition and meal planning
- ☐ Proper exercise routines and techniques
- ☐ How to deal with LifeStyle stress

YOUR HEALTH



Please place an "X" on the scale above marking where you believe your level of health and wellness is at this time. Place a "O" on the diagram indicating where you would like your health and wellness to be.

THE BEGINNING YEARS

Research is showing that many of the health challenges that occur later in life originate during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Birth to 17 years of age	Yes	No	Unsure
Did you have any serious childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs? (prescribed or not)	☐	☐	☐
Did you have any surgeries?	☐	☐	☐
Were you involved in any car accidents?	☐	☐	☐
Was there prolonged use of medicine (antibiotics, inhaler, etc)	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
Were you under regular Chiropractic Care?	☐	☐	☐

Adults – (18 to present)	Yes	No	Unsure
Do/did you smoke?	☐	☐	☐
Do/did you drink alcohol? (more than socially)	☐	☐	☐
Have you been in any accidents?	☐	☐	☐
Have you had any surgeries?	☐	☐	☐
Do you play any adult sports?	☐	☐	☐
Do/did you participate in extreme sports?	☐	☐	☐

HABITS *(presently)*	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Have you seen other healthcare professionals for the reason you're here today? (*please include name and date*)

Physiotherapist: _____

Massage Therapist: _____

Acupuncturist: _____

Chiropractor: _____

Other: _____

PEAK PERFORMANCE
Health Center

Dr. Matt Hutt
Dr. Dave Dunnett
Dr. Steve Howard

Standard Form – 36 (SF-36)

Patient Name:	Date:

INSTRUCTIONS: This survey asks for views about your health. This information will help keep track of how you feel and how well you are able to do your usual daily activities. Answer every question by circling the best answer. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:	1. Excellent 2. Very Good 3. Good	4. Fair 5. Poor

2. Compared to one year ago, how would you rate your health in general at this time?	1. Much better now than one year ago 2. Somewhat better than one year ago 3. About the same as one year ago	4. Somewhat worse than one year ago 5. Much worse now than one year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Activities	Yes, a lot	Yes, a little	Not limited
a. Vigorous activities, such as running, lifting heavy Objects, or participation in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, Vacuuming, bowling or golfing	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of your physical health?

a. Cut down on the amount of time you spent on work or activities	Yes = 1	No = 2
b. Accomplished less than you would like	Yes = 1	No = 2
c. Were limited in the kind of work or other activities	Yes = 1	No = 2
d. Had difficulty performing the work or other activities (For example – requiring an extra effort)	Yes = 1	No = 2

PEAK PERFORMANCE
Health Center

Dr. Matt Hutt
Dr. Dave Dunnett
Dr. Steve Howard

5. During the past four weeks, have you had any of the following problems with your work or other regular daily activities as result of any emotional problems (such as depressed or anxious)?		
a. Cut down on the amount of time you spent on work or other activities	Yes = 1	No = 2
b. Accomplished less than you would like	Yes = 1	No = 2
c. Didn't do work or other activities as carefully as usual	Yes = 1	No = 2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?	1. Not at all 2. Slightly 3. Moderately	4. Quite a bit 5. Extremely

7. How much bodily pain have you had during the past 4 weeks?	1. None 2. Very mild 3. Mild	4. Moderate 5. Severe 6. Very severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?	1. Not at all 2. Slightly 3. Moderately	4. Quite a bit 5. Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives etc.)?	1. All of the time 2. Most of the time 3. Some of the time	4. A little of the time 5. None of the time

11. How TRUE or FALSE is each of the following statements to you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

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 effected 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 ro neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or a 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 damage 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 odd 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 rain 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