



# ALL SEASONS CHIROPRACTIC

**Services provided by Trevor Winzowski Chiropractic Corp.**  
185a Stone Bridge Crossing, Steinbach, MB, R5G 2J2 Telephone 204-326-5800

## ADULT / YOUTH INTAKE FORM

DATE: \_\_\_\_\_, 20\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Height: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Current Age: \_\_\_\_\_

MHSC Registration # (9 DIGIT) \_\_\_\_\_ # (6 DIGIT) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home ph #: \_\_\_\_\_ Wk #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_

**Yes! Please send me ( ) text message alerts or ( ) emails for upcoming appointments/events**

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ # of Children (if any): \_\_\_\_\_

Ages of Children: \_\_\_\_\_ Are you Pregnant? YES NO (circle)

How did you hear about our Office? \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Will you be claiming: Autopac (MPI)? Y / N (circle) Worker's Compensation? Y / N (circle)

If yes: Injury/Accident Date: \_\_\_\_\_

Injury Claim #: \_\_\_\_\_

### **CHIROPRACTIC HISTORY:**

Have you ever been to a chiropractor before?: Y / N Date of last visit: \_\_\_\_\_

Name of last chiropractor: \_\_\_\_\_

What are your health goals?  Symptom relief  Wellness care  100% potential!

Please list all medications and doses that you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\* Please also complete page 2 of Intake Form \*\***

## **YOUR HEALTH HISTORY**

**Please check all that you have experienced in the last 6 months:**

- |  |                                       |  |   |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Migraines    | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Sinus problems   |
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Neck Pain    | <input type="checkbox"/> Shoulder Pain   | <input type="checkbox"/> Ringing in ears  |
| <input type="checkbox"/> Ear infections  | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Hand/wrist pain  |
| <input type="checkbox"/> Tinnitus        | <input type="checkbox"/> Chest pain   | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Mid back pain    |
| <input type="checkbox"/> Rib pain        | <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Low back pain    |
| <input type="checkbox"/> Knee pain       | <input type="checkbox"/> Heartburn    | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Hip pain         |
| <input type="checkbox"/> Ankle/knee pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Menstrual cramps |
| <input type="checkbox"/> Cancer          |                                       |  |   |
- 

**Why are you here to see the Chiropractor TODAY?**

**Problem 1:** \_\_\_\_\_

On a scale of 1 to 10 (10 being severe), how bad is the problem? \_\_\_\_\_ /10

When did it start? \_\_\_\_\_ How? \_\_\_\_\_

Is the condition:     getting better     getting worse     staying the same?

How would you describe the problem? \_\_\_\_\_

Are you taking medication for this condition?    Yes    No    (please circle)

If yes, which medication and in what doses? \_\_\_\_\_

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**Problem 2:** \_\_\_\_\_

On a scale of 1 to 10 (10 being severe), how bad is the problem? \_\_\_\_\_ /10

When did it start? \_\_\_\_\_ How? \_\_\_\_\_

Is the condition:     getting better     getting worse     staying the same?

How would you describe the problem? \_\_\_\_\_

Are you taking medication for this condition?    Yes    No    (please circle)

If yes, which medication and in what doses? \_\_\_\_\_

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**Problem 3:** \_\_\_\_\_

On a scale of 1 to 10 (10 being severe), how bad is the problem? \_\_\_\_\_ /10

When did it start? \_\_\_\_\_ How? \_\_\_\_\_

Is the condition:     getting better     getting worse     staying the same?

How would you describe the problem? \_\_\_\_\_

Are you taking medication for this condition?    Yes    No    (please circle)

If yes, which medication and in what doses? \_\_\_\_\_

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**OR:**    [   ]    I have no specific symptoms or complaints. I am here mainly for a spinal check up and wellness services.



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## CONSENT TO CHIROPRACTIC TREATMENT

It is important for you 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 caused by 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 or 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 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 or Parent/Guardian Signature

\_\_\_\_\_  
Chiropractor Signature

Date: \_\_\_\_\_, 20\_\_\_\_