Confidential Case History

DATE: ______________________

Please complete the following questionnaire. Your answers will help us to determine if Chiropractic can help you. Thank you!

First & Last Name: Date of Birth (dd/mm/yy): Age:

Address: City/Prov.: Postal Code:

Occupation: Name of Business:

Home Phone #: Cell #: Work #: Email:

AHC# Martial Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Gender: ☐ Male ☐ Female

Spouse's Name: Emergency Contact: Number:

Number of Children: Children's Names (Ages):

Referred by:

Related to recent motor vehicle accident? ☐ Yes ☐ No Date of accident:

Work injury? ☐ Yes ☐ No Date of accident:

HEALTH INFORMATION

Reason for attending office:

Location of pain:

When did it begin? How often does it occur?

Does it radiate? ☐ Yes ☐ No If yes, where?

What relieves it?

What aggravates it?

Describe how it interferes with your life, work or hobbies:

When have you had this or similar conditions in the past?

Is condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Have you had previous Chiropractic? ☐ Yes ☐ No

Pain based Chiropractor or Wellness Chiropractor? When?

Why? Were x-rays taken? ☐ Yes ☐ No

Other treatments tried:

How long has it been since you really felt good?

PAST HEALTH HISTORY

Please check if you presently have or have had any of the following conditions in the past:

☐ Blurring of Vision
☐ Stroke
☐ Dizziness
☐ High Blood Pressure
☐ Heart Disease
☐ Aneurysm
☐ Varicose Veins
☐ Osteoporosis
☐ Bronchitis
☐ Asthma
☐ Respiratory condition
☐ Chest Pains
☐ Diabetes
☐ Hiatus Hernia
☐ Constipation
☐ Neck Pain
☐ Diarrhea
☐ Stomach Ulcer
☐ Heart Burn
☐ Headaches
☐ Allergies
☐ Sinusitis
☐ Ringing in Ears
☐ Upper Back Pain
☐ Insomnia
☐ Tendonitis
☐ Urinary Frequency
☐ Arthritis
Where? ______________
☐ Numbness or Tingling ☐ Arms or ☐ Legs
☐ Menstrual Problems
☐ Low Back Pain

Any family health conditions: ☐ Yes ☐ No Please list:

Do You Have Any Other health problems?

List your surgical operations or hospitalizations?

Women: Is there a chance that you could be pregnant? Y / N

List of medications you now take:

Rate your diet:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your sleep habits:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your exercise:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your mental state:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent

List and describe any prior auto accidents or other accidents/injuries and when they occurred:

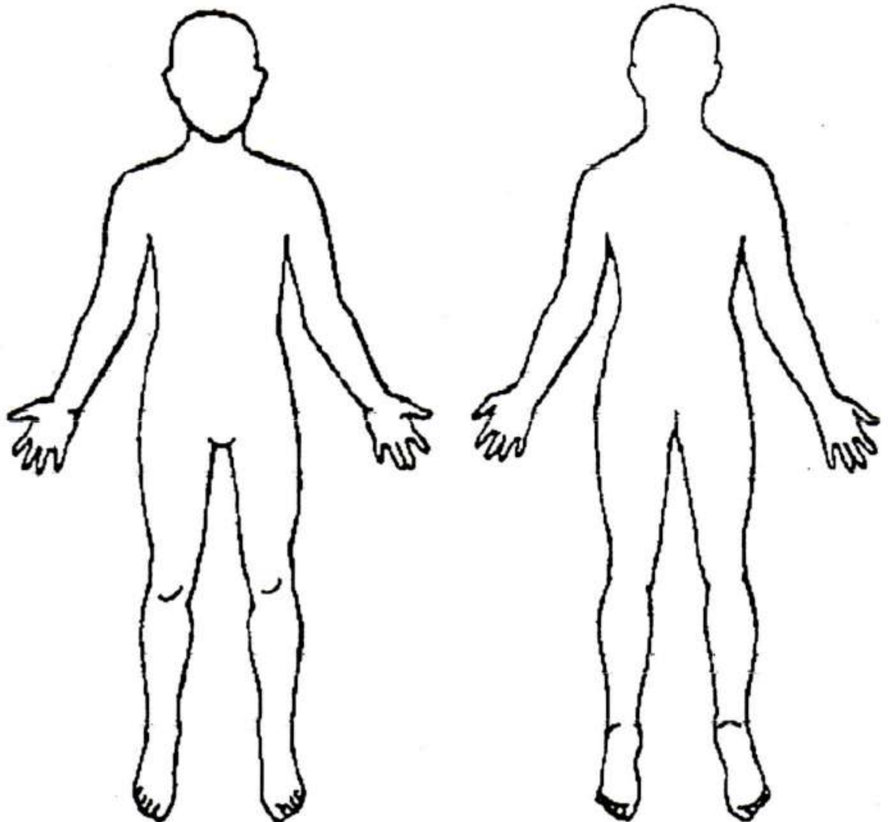
Do you: Drink? ☐ No ☐ Yes - How many glasses /week? Smoke? ☐ No ☐ Yes How much?

List and describe any childhood injuries/accidents/hospitalizations/illnesses and when:

Anything else you feel we should know about?

Draw in your face.
Show area(s) of pain or unusual feeling.
Mark the areas on this body where you feel the Described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.

Numbness	● ● ● ● ● ● ● ● ● ● ● ● ● ● ●
Pins & Needles	o o o o o o o o o o o o o o o
Burning	X X X X X X X X X X X X X X X
Aching	■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■
Stabbing/Sharp	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐



Langdon Chiropractic

(403)-936-2450

INFORMED 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

OFFICE FEE SCHEDULE AND FINANICAL POLICY

New Patient Service

Initial Exam	$ 80
Initial Exam Child	$ 40

Services

Regular Office Visit / Adjustment	$ 60
Child Office Visit	$ 35
Student (secondary) / Senior +65	$ 40
Decompression Therapy	$ 80

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal.

- You will be expected to pay for your chiropractic care at the time service is rendered.

If you are injured in an auto accident, and have coverage, we will discuss billing options with you.

I have read and I understand the above policies.

Date ____________ Patient Signature ____________ Printed Name ____________