THRIVE
Chiropractic & Wellness Centre

Name: _____ Birthdate: _____ Age: _____

Address: _____ Sex: Male _____ Female _____

City: _____ Postal Code: _____ Phone (cell): _____

Email: _____ Phone (work): _____

Occupation: _____ Employer: _____

Alberta Health Care #: _____

*Please be advised that personal health care numbers are collected in accordance with the Alberta Health Act. Numbers are protected and used solely for the purposes of diagnosis, treatment, and referral. Alberta Health Care currently does not make payments for any portion of treatment offered at Thrive Chiropractic & Wellness Centre.

Emergency Contact Name: _____ Phone: _____

Parent Contact (if patient is <18 years of age): _____

Are you currently a **student**? Yes ____ No ____

Is there a chance you could be **pregnant**? Yes ____ No ____

Is this related to a **motor vehicle accident**? Yes ____ No ____

If yes, date of accident: _____

Is this related to a workplace injury (**WCB claim**) Yes ____ No ____

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

If you were not referred by a friend or family, how did you hear about our office?_____

Have you been to a Chiropractor before? Yes No

If Yes, who _____ When was your last visit? _____

Do you wear orthotics or special shoe inserts? Yes No If yes, how old are they? _____

Have you received **spinal x-rays** in the past 2 years? Yes No

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Specific Concern History

Reason for today's visit: Wellness Check-up or Specific Concern

Please describe your primary concern: _____

When did this problem begin? _____

How frequent is this problem? Constant Daily Weekly Other:_____

How has it progressed recently? Same Improving Getting Worse

Describe the pain: Sharp Dull Numbness Tingling Aching
Burning Stabbing Throbbing Other:_____

Does the pain radiate into: Yes No If Yes, where? _____

On a scale of 1 (no pain) to 10 (severe pain), rate your pain: ____average ____ at best ____ at worst

What aggravates this problem: _____

Have you experienced a similar problem in the past? Yes No When: _____

Does this condition affect your:	**What relieves the pain and/or symptoms?**	**Check all the TRUE statements:**
_____ Career	_____ Medication	_____ Previous help has been ineffective
_____ Family Life	_____ Physical Therapy	_____ My problem could get worse
_____ Ability to exercise	_____ Exercise/Stretching	_____ I want answers and results
_____ Sleep	_____ Massage Therapy	_____ I want better health
_____Quality of Life	_____ Nothing	
Other _____	Other _____	

How long has it been since you really felt well? _____

Rate the importance of finding the **CAUSE** of your problem: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate the importance of your quality of life: (low) 1 2 3 4 5 6 7 8 9 10 (high)

My biggest obstacles to getting well will be: Time Money Other:_____

As a result of my chiropractic care, I would like to: (Please circle all that apply)

Feel better quickly Long lasting results Correct the problem Prevent permanent damage

SYSTEMS REVIEW			
Please check any symptoms currently affecting your quality of life (even if you do not believe them to be chiropractic related)			
___ Headaches/Migraines	___ Upper Back Pain	___ Lower Back Pain	___ Fatigue
___ Neck Pain	___ Shortness of Breath	___ Constipation	___ Sleeping Problems
___ Shoulder Pain	___ Chest Pain	___ Bloating/Gas	___ Frequent Colds/Flus
___ Arm/Hand Pain	___ Rib Pain	___ Diarrhea	___ Scoliosis
___ Carpal Tunnel	___ Asthma	___ Sciatic Pain	___ Arthritis
___ Allergy/Sinus Problems	___ Heartburn	___ Leg Pain	___ Osteoporosis
___ High Blood Pressure	___ Chronic Cough	___ Foot Pain/Numbness	___ Cancer
___ Vision Changes		___ Cramping in Legs	___Depression
___ Dizziness/Vertigo		___ Bladder Control	___ Anxiety
___ Ear Infections		___ Sexual Dysfunction	
___ ADD/ADHD		___ Bedwetting	

WOMEN ONLY			
___ Painful Menstruation	___ Irregular Cycles	___ Infertility	___ Miscarriage
___ Early Menopause	___ Hot Flashes	___ Endometriosis	___ PMS
# of pregnancies _____		# of births _____	
Have you ever experienced with birth?	___ C- Section	___ Epidural	___ Induction
	___ Forseps	___ Vacuum Suction	___ Breech Baby

Is there a family history of: (circle all that apply)

Heart disease Stroke Cancer Diabetes Other:_____

Please list any medications or vitamins you are currently taking and reason for taking:

_____ _____

_____ _____

_____ _____

List any surgeries you have had and include when:

_____ _____

_____ _____

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