Spinalcare CHIROPRACTIC CLINIC

PATIENT ENTRANCE FORM

(PLEASE PRINT)

Name _____ Date _____

Address _____ City _____

Province _____ Postal Code _____ E-mail _____

Home Tel _____ Work phone _____ Cell phone _____

Date of Birth (D/M/Y) ____/____/_____ Age _____ Sex M / F Martial Status – S M D W

Weight _____Height _____ Occupation _____ Pregnant? _____

Spouse's or Parent's Name _____ No. of children _____

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

Have you ever had Chiropractic Care before? Yes / No If so, when? _____

Contact information of your family doctor:

Name _____ Address/Phone _____

Your Health Profile

As a full spectrum solution-based Chiropractic office. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity to improve your health potential and wellness. On a daily basis we experience physical, chemical, and emotional stress that can accumulate and result in serious loss of health potential. Most time the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

CHILDHOOD and ADOLESCENCE STRESSES

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

Y / N Did you have any childhood illnesses?	Y / N Did you have any serious falls as a child?
Y / N Did you play youth sports?	Y / N Did you take/use recreational drugs?
Y / N Was there prolonged use of antibiotics or inhaler?	Y / N Were you vaccinated?
Y / N Were teeth extracted or dental orthodontics used?	Y / N Were you involved in any car accidents?
Y / N Did you suffer any physical or emotional traumas?	Y / N Were you under regular Chiropractic Care?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None	Moderate			High		None	Moderate			High
Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

Please list any drugs/medication/supplements you take:

MEDICATIONS:

__Pain __Blood Pressure __Cholesterol __Heart __Anxiety __ Blood Thinner

SUPPLEMENTS:

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None	Moderate			High		None	Moderate			High
Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

Your Current Health Goals

Please list your current health goals, such as exercise, diet, stress management … A C W

1. _____
2. _____
3. _____

Family History

Our office attracts and cares for families. We are interested in how their health background may affect you, and your specific concerns. Please note any health concerns you have knowledge of.

Name	Relationship	Past & Present Health Problems
1.		
2.		
3.		
4.		

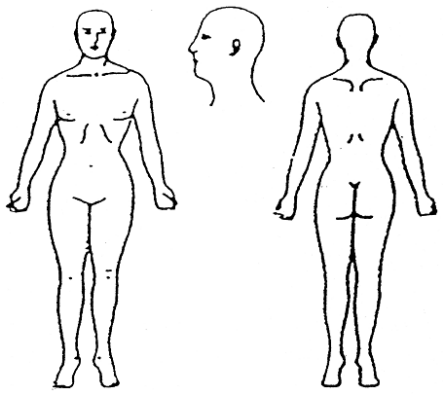
Your Current Concerns

If you have no complaints or symptoms, and are here for your wellness assessment, Please Check ____ and proceed to the next page.

Please place a vertical mark on the line below to rate your pain:

0 — 0 (no pain) to 10 (extreme pain) — 10

Please mark the area(s) of the body where you do not feel well



Notice to patient:

1. Patient Privacy

   Your information provided will be used for healthcare and communication purposes only. Our clinic will keep your information confidential as required by law.

2. Cancellation/ No Show Policy

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. ***If an appointment is not re-scheduled/cancelled <u>at least one business day</u> in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.***

3. Refund Policy

   Any service (such as consultation, examination, treatment, shipping & handling, etc.) rendered is not eligible for refund.
   Dietary supplement, health, and personal care items (such as pillow) is not eligible for refund.

4. In this clinic, as a service to you, also provides additional services and products, including but not limited to acupuncture, massage therapy, nutritional consultations, dietary supplements, custom-made orthotics, fat burning & detox programs and personal training programs. The above services and products are recommended according to individual needs.

You are under no obligation to use or purchase the above services and products at our clinic. In addition, regardless whether you prefer to use our additional services/products or not, you nevertheless have the best of our care.

5. Informed Consent to Examination

   I hereby request and consent to the performance of a Chiropractic, Orthopedic and Neurological examination, and diagnostic x-rays (if required) which will determine if Chiropractic can help me. I understand that in some cases, the examination may aggravate my present condition.

I, _____ have read and understand the above statements.
(Print Name)

Signature _____ Date _____

Spinalcare
CHIROPRACTIC CLINIC

" An ounce of prevention is worth a pound of cure."

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