Envive Chiropractic
161 Harwood Avenue N Unit 7B
Ajax, Ontario
L1Z 0A1
905-427-6772

Dr. Cecile Thackeray
Dr. Jennifer Royer

Patient Entrance Form

QOL:

Name: _____ Date: _____

Address: _____ City:_____ Postal Code: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Email : _____ Occupation : _____

Date of Birth:(M/D/Y)____ /____ /____ Age: ____ Married □ Single □ Widowed □ Divorced □ Children _____

Name of Family Doctor: _____ Referred By: _____

Emergency Contact: _____ Phone #: _____

What symptom(s) brought you in today? (List in order of severity)

1) _____ When did it start? _____ Intensity _____/10

□Sharp □Stabbing □Dull □Achy □Throbbing □Numb □Tingling Radiates (If Yes to Where) _____

2) _____ When did it start? _____ Intensity _____/10

□Sharp □Stabbing □Dull □Achy □Throbbing □Numb □Tingling Radiates (If Yes to Where) _____

3) _____ When did it start? _____ Intensity _____/10

□Sharp □Stabbing □Dull □Achy □Throbbing □Numb □Tingling Radiates (If Yes to Where) _____

Is your problem the result of: □ Auto Accident □ Work Accident □ Slip & Fall

Aggravating Factors:

□ Cough □ Sneeze □ Lifting □ Bending □ Twisting

□ Sitting □ Standing □ Walking □ Driving

□ Stairs Up □ Stairs Down □ Getting up from chair

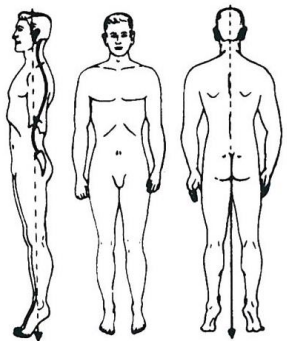
□ Getting in /out of car

Relieving Factors:

□ Ice □ Heat □ Massage □ Stretching

□ Sitting □ Standing □ Laying Down

□ Other: _____



Please Circle Area(s) of Pain

Previous Treatments: □Chiropractor □Physiotherapy □Massage □ Other: _____

Last treatment date: _____

Motor Vehicle Accidents: □ Yes □ No When: _____

Info Regarding any Previous Trauma: _____

Surgeries: □ Yes □ No When: _____

Fall on Tailbone □ Yes □ No When: _____ **Hit to the Head** □ Yes □ No When: _____

Slips and/or Falls: □ Yes □ No _____ When: _____

Do you play or have you previously played any sports? □ Yes □ No **Details:** _____

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Previous Diagnosis:

Arthritis Cancer Hypertension Diabetes Heart Disease Skin Disorder Depression Anxiety

Fibromyalgia TMJ Disc Herniation Allergies Psychological Lung Disorder Stroke

Hereditary Factors (Describe family history):_____

Medications:_____

Please Mark All That Apply

Blood Pressure		Hepatitis		Eczema	
Chest Pain		Easy Bruising		Psoriasis	
Palpitations		Coughing		Skin Reaction	
Swelling		Asthma		Liver Disease	
Cloudy Head		Allergies		Thyroid Disease	
Loss of Memory		Herniated Disc		Frequent Colds	
Problems Concentrating		Shortness of Breath		Diabetes	
Kidney Stones		Ringing in Ears		Fatigue	
Bladder Infection		Dizziness		Gout	
Frequent Urination		Hearing Loss		Mood	
Stomach		Sinus		Arthritis	
Gall Bladder		Balance		Jaw Problems	
Constipation		Headaches		Osteoporosis	
Diarrhea		Eyewear		Breast Lump	
Gas		Glaucoma		Menstrual Pain	
Heartburn		Prostate Problems			
Vomiting		# of Pregnancies		Weight (lbs) :	
Alcohol: drinks/week		Smoking: packs/day		Coffee: cups/day	

Rate Your Level of Stress: Absence 1 2 3 4 5 6 7 8 9 10 Extreme

Rate Your Level of Energy: Absence 1 2 3 4 5 6 7 8 9 10 Extreme

Rate on a Scale of Poor, Good, or Excellent	
Diet:	
Exercise:	
General Health:	
Sleep:	

Sleep Position:	Side □ Back □ Stomach □
# of Hours Sleep/Night:	
Trouble Falling Asleep?	
Trouble Staying Asleep?	

Disclosure of Personal Health Information

We are concerned with protecting the privacy of your personal health information. The law requires us to notify you about this disclosure. It may be necessary for us to disclose your health information to another health care provider if it is necessary for us to disclose your health information to them for the diagnosis, assessment, or treatment of your health condition.

Patient or Guardian Signature: _____ Date: _____

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of stroke. In essence there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused by spinal adjustments or other chiropractic treatment

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general (including the spinal adjustment), the treatment options and recommendations for my condition and the contents of this consent. I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature: _____ **Witness of Signature: _____**

Name: _____ **Name: _____**

(please print) **(please print)**