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

envive chiropractic
A B C D

Dr. Jennifer Royer
Dr. Marianne Ralph

New Patient

QOL: Date: ____________________

Name: ____ Date of Birth: ______________________ Age: __________

Address (street/city/postal code): ____

Primary Phone #: _________________________________ Email : ____

Occupation : _____________________________________ ☐ Married ☐ Single ☐ Children #_____ Gender: _________

Emergency Contact (name & phone #): ____

Family Doctor: ____________________________________ Referred By: _____________________________________

Is your problem the result of: ☐ Car Accident ☐ Work Accident **Are you Pregnant?** ☐ Yes: #weeks______ ☐ No

What symptom(s) brought you in today?

1) ____ Started ________________ Intensity ____/10

☐ Sharp ☐ Dull ☐ Achy ☐ Numb ☐ Tingling ☐ Burning

2) ____ Started ________________ Intensity ____/10

☐ Sharp ☐ Dull ☐ Achy ☐ Numb ☐ Tingling ☐ Burning

3) ____ Started ________________ Intensity____/10

☐ Sharp ☐ Dull ☐ Achy ☐ Numb ☐ Tingling ☐ Burning

What makes it worse: ____

What makes it better: ____

Previous Treatments: ☐ Chiropractor ☐ Physiotherapy ☐ Massage When?:__________

Current/Previous Sports: ____

Car Accidents: ☐ Yes ☐ No When?: ____

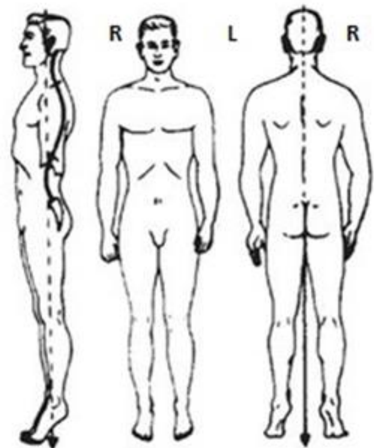
Fall on Tailbone: ☐ Yes ☐ No Hit to the Head: ☐ Yes ☐ No Slips and/or Falls: ☐ Yes ☐ No

____

____

Previous Trauma/Surgeries: ____

Current Medications: ____



Please Circle Area(s) of Pain on Body Diagram

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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): ____

Please Check All That Apply:

(**P**=have had in the past **C**=current within the last 6 months)

	P	C		P	C		P	C
Blood Pressure			Ulcers			Skin Issues		
Chest Pain			Easy Bruising			Liver Disease		
Palpitations			Coughing			Thyroid Disease		
Swelling			Asthma			Diabetes		
Cloudy Head			Allergies			Frequent Colds		
Loss of Memory			Herniated Disc			Fatigue		
Problems Concentrating			Shortness of Breath			Mood		
Kidney Stones			Ringing in Ears			Arthritis		
Bladder Infection			Dizziness			Osteoporosis		
Frequent Urination			Hearing Loss			Jaw Problems		
Stomach Problems			Sinus			Fainting		
Gall Bladder			Balance			Pins & Needles		
Constipation			Headaches			Numbness		
Diarrhea			Eyewear			Breast Lump		
Gas			Eye Issues			Menstrual Pain		
Heartburn			Light Sensitivity			Prostate Problems		
Vomiting			# of Pregnancies			Weight (lbs) :		
Alcohol: drinks/week			Smoking: #/day			Coffee: cups/day		

Rate your **Stress Level:** Low 1 2 3 4 5 6 7 8 9 10 High

Rate your **Energy Level:** Low 1 2 3 4 5 6 7 8 9 10 High

	Poor	Good	Excellent
Diet	☐	☐	☐
Exercise	☐	☐	☐
General Health	☐	☐	☐
Sleep	☐	☐	☐

Sleep Position: ☐ Side ☐ Back ☐ Stomach
Trouble Falling Asleep: ☐ Yes ☐ No
Trouble Staying Asleep: ☐ Yes ☐ No
# of Hours Sleep/Night: _______________

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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 exam.

Patient Name: ________________________________ **Doctor:** ___________________________________

Patient Signature: _____________________________ **Doctor Signature:** ___________________________

Date: ______________________

I consent to the 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.

Patient Signature: _____________________________ **Doctor Signature:** ___________________________