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

envive chiropractic

Dr. Cecile Thackeray
Dr. Jennifer Royer
Dr. Marianne Ralph

Patient Entrance Form

QOL: Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City:_____ Postal Code: _____

Primary Phone #: _____ Secondary Phone #: _____

Email : _____ Occupation : _____

□ Married □ Single □ Widowed □ Divorced □ Children #___ Referred By: _____

Emergency Contact: _____ Phone #: _____

Name of Family Doctor: _____ Vaccine: Date of last dose _____Brand_____

Is your problem the result of: □ Auto Accident □ Work Accident **Are you Pregnant?** □ Yes □ No _____#weeks

What symptom(s) brought you in today?

1) _____ Started _____ Intensity _____/10

□ Sharp □ Dull □ Achy □ Numb □ Tingling □ Burning □ Constant □ Comes & Goes

2) _____ Started _____ Intensity _____/10

□ Sharp □ Dull □ Achy □ Numb □ Tingling □ Burning □ Constant □ Comes & Goes

3) _____ Started _____ Intensity_____/10

□ Sharp □ Dull □ Achy □ Numb □ Tingling □ Burning □ Constant □ Comes & Goes

Hurts:

□ Cough □ Sneeze □ Lifting □ Bending □ Twisting

□ Sitting □ Standing □ Walking □ Driving

□ Stairs Up □ Stairs Down □ Getting up from chair

□ Getting in /out of car

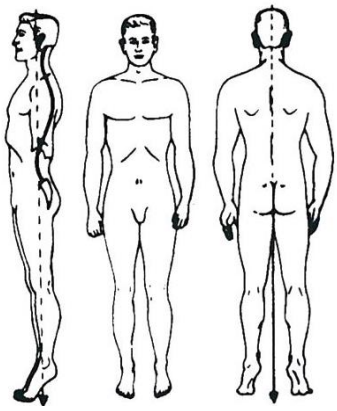
Helps:

□ Ice □ Heat □ Massage □ Stretching

□ Sitting □ Standing □ Laying Down

□ Pain Medication _____

□ Other: _____



Please Circle Area(s) of Pain

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

Current/Previous Sports: _____

Motor Vehicle Accidents: □ Yes □ No Date: _____

Fall on Tailbone □ Yes □ No Date: _____

Hit to the Head □ Yes □ No Date: _____

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

Previous Trauma: _____

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Previous Surgeries: _____

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			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: #/day			Coffee: cups/day		

Current Medications: _____

Rate Your Level of Stress: None 1 2 3 4 5 6 7 8 9 10 Extreme

Rate Your Level of Energy: None 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?	

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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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 and 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 Name: _____ **Doctor:** _____

Patient Signature: _____ **Doctor Signature:** _____

Date: _____