Labelle Chiropractic Clinic

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Welcome To Our Office

Outline of procedures for new patients:

Step 1:

All new Patients are requested to thoroughly complete a confidential **"Patient Health Record".**

Step 2:

Your first **Consultation** with the doctor to discuss your health problems.

Step 3:

You will receive a **"Comprehensive Examination"** to determine if chiropractic care is appropriate for your condition - an in-depth, advanced assessment of your nervous system to determine how well your brain is communicating with your body. Any interference to this communication may be measured by the following tests: **(spinal function), Range of Motion, Postural Assessment, Muscle Testing, Nerve Testing, Bilateral Weight Scales and Balance.** As well, if indicated, **x-rays** will be taken to visualize the location of spinal problems.

Step 4:

You will be advised as to a time you can return for your "**Report of Findings"** when your doctor will inform you as to your examination results and whether or not your case has been accepted. If accepted, your recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

Step 5:

Chiropractic care will begin after your Report of Findings and continue as scheduled until your condition has been fully corrected, or until **maximum possible improvement has been obtained**.

To save time and allow us to better serve you, please complete all questions on the next 3 pages. Thank you!

Personal History

Name: ___________________________ Address: ___________________________

City: ___________ Province: _____ Postal Code ________ E-mail Address: ___________________________

Home Phone: __________________ Work Phone: ______________________ Cell Phone: ______________________

Birthdate: (d/m/y)____________ Age: _____ Sex: □ M □ F Type of Work: ___________________________

Circle One: married single widowed divorced separated Common law Number of Children: ______________________

Names and ages of Children: ___________________________

Emergency Contact: ______________________ Phone #: ________________ Relationship: ________________________

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

Current Health

Main/Current Health Concern(s): ___________________________

Other doctors seen for this concern? □ Yes □ No Type? ___________________________

Type of Treatment: ____________________________ Results: ___________________________

When did this begin? ___________________________ Has it occurred before? □ Yes □ No

What makes this worse? □ Sitting □ Standing □ Bending □ Lifting □ Walking
□ Lying Down □ Cold □ Dampness □ Other: ______________________

What makes it better? □ Bed Rest □ Ice □ Heat □ Massage □ Medication □ Chiropractic □ Other: __________

Character of Discomfort: □ Sharp □ Dull □ Ache □ Pins & Needles/Numb □ Constant □ Intermittent □ Burning

What else have you tried to do to get rid of this? ___________________________

Place an X on the scale to indicate the severity of your discomfort:(if applicable)

Least 1 2 3 4 5 6 7 8 9 10 *Worst*

Does this problem interfere with:

Work? □ Yes □ No Family or social time? □ Yes □ No Your hobbies or sports? □ Yes □ No

Drugs you take now: □ Nerve Pills □ Painkillers/Muscle Relaxants □ Blood Pressure Medicine
□ Insulin □ Other: ___________________________

Do you currently wear custom orthotics/shoe inserts?___________________________

Have you had x-rays taken in the last six months? □ Yes □ No If Yes, where? ___________________________

On a scale of 1 to 10, 10 being the highest, rate your commitment in helping us solve this problem: __________________

Past Health History

Major Surgery/Operations: ___________________________

Previous: Childhood Traumas □ ____________ Motor Vehicle Accidents □ ____________ Sports Injuries □ ____________
Work Injuries □ _________________________Hospitalization (other than above): ________________________

Family Health History

Name of Family Physician: ___________________________

Please indicate any health issues that are present in your family:

Parents: ____________________________________ Siblings: ___________________________

Does any member of your family suffer from the same condition (as you)? □ No □ Yes Whom? ______________________

Have your children ever had a spinal check-up? □ No □ Yes □ If Yes, where and when? ____________________________

Below is a list of symptoms or diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have had in the past six months even if they do not seem related to your current problem:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/clicking Jaw
- ☐ General Stiffness

Satisfaction with Diet
- ☐ Highly Satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Intake
- ☐ Coffee ☐ Tea
- ☐ Alcohol ☐ Cigarettes
- ☐ White Sugar

Do you have a regular exercise program? ☐ Yes ☐ No

How often do you exercise?
- ☐ 1-2 times per week
- ☐ 2-4 times per week
- ☐ 4 or more times per week

Sleeping Position

☐ Back ☐ Side ☐ Stomach

Type of mattress: _______________

Age of mattress: _______________

Is they comfortable? ☐ Yes ☐ No

Type of Pillow: _______________

Age of Pillow: _______________

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Lifestyle Stress Levels
- ☐ High
- ☐ Moderate
- ☐ Very Little
- ☐ None

Check any of the following diseases you have had:
- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema
- ☐ Psoriasis

Gastro-Intestinal
- ☐ Black/Bloody Stool
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating after meals
- ☐ Colitis

Male/Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

Female

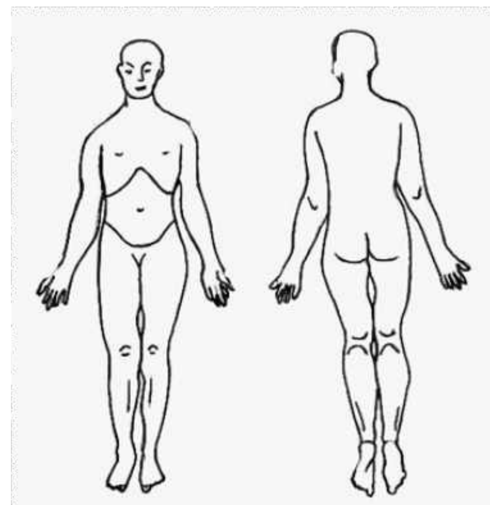
When was your last period?

____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discoloured Urine



Please outline on the diagram the area of your discomfort and any radiation of pain.

Why Chiropractic Care?

People go to a chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (**Preventative Care**). These are the three types/phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three types/phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐ **Preventative Care –** Life Enhancement and Wellness Care
- ☐ **Corrective Care** – Removing Cause and Remodeling Soft Tissue
- ☐ **Relief Care –** Band-Aid Care only
- ☐ Check **here** if you want the doctor to select the type of care appropriate for your condition.

Please read carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

In order for the Doctor at the Labelle Chiropractic Clinic to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiograph examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by him or her or any party authorized to do so by them.

_______________________________ ____________

Patient Signature/Guardian's Consent Date