

Adult Confidential Health Questionnaire

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PERSONAL INFORMATION

Today's Date: ____/____/____
M / D / Y

Name: _____ Age: _____

Home Address: _____ City: _____ Province: _____ Postal Code: _____

Email Address: _____ Cell Phone: () _____ Home Phone: () _____

Do you have extended health insurance coverage? YES NO

Insurance Company: _____ ID # _____ POLICY/GROUP # _____

How were you referred to this office? Online Walked-by Community Event

Referred by a friend/family/co-worker : Referrals First Name: _____ Last Name: _____

Would you like to receive email reminders **or** text message reminders the day before your next appointment?

(Cell phone **provider** needed for text reminders _____)

Birth Date: ____/____/____ M / D / Y Occupation: _____ Employer Name: _____

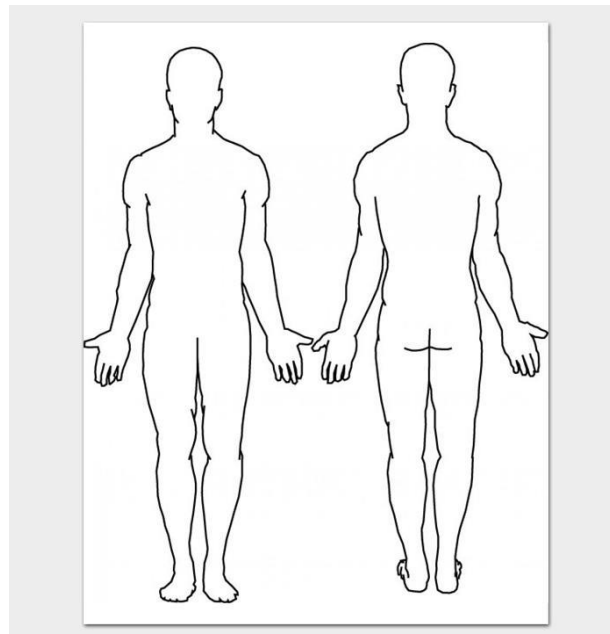
Emergency Contact Name: _____ Phone: () _____

Purpose of This Visit

What brings you to our office? _____

Areas of Complaint or Issue(s)

(Please indicate any areas of pain/complaint/dysfunction on the diagram below)



Experience with Chiropractic

Have you ever been to a Chiropractor before? YES NO How long ago? _____

Reason for visits: _____ How did you respond to your care? _____

Health History and Conditions

Do you smoke? YES NO How much? _____

Are you pregnant? YES NO Are you trying to become pregnant? YES NO (For women only)

Are you diabetic? YES NO

Are you on any medications? YES NO

Medication

Reason for taking

<i>Medication</i>	<i>Reason for taking</i>
_____	_____
_____	_____
_____	_____
_____	_____

Please list any major surgeries, accidents, hospitalizations, or childhood illnesses:

PLEASE LIST ANY OTHER HEALTH CONDITIONS, CONCERNS, OR MEDICAL DIAGNOSES NOT MENTIONED: _____

INFORMED 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 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. Patient 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 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 caused 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)

Signature of patient (or legal guardian)

Date: _____

Signature of Chiropractor

Date: _____



CANCELLATION POLICY

Please note, we require a minimum of 24 hour's notice in the event of an appointment cancellation (exemption made for emergency situations). Should an appointment be missed or cancelled within 24 hours, a \$30 cancellation fee will be applied and charged at your next appointment. Should an appointment be missed more than twice, a credit card will be required to be kept on file for future appointments.

By signing this, you agree to Progressive Chiropractic's cancellation policy.

Printed Name	Signature	Date
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Direct Billing Consent, Authorization and Acknowledgement (Only applicable to patients with insurance coverage)

Consent to Collect and Exchange Personal Information:

I authorize my health care provider, Progressive Chiropractic, to use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers for the purposes of assessing my claims, investigations, and administering the group benefits plan.

I confirm I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons as stated above.

I hereby authorize my health care provider to direct bill my insurance company on my behalf for services provided at Progressive Chiropractic. I acknowledge that if my claim is not paid in part or whole, or is not paid directly to the health care provider, that I will pay any balance owing immediately after treatment.

Printed Name	Signature	Date
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Lifestyle Survey

.How many hours per day do you sit? (circle the best answer that applies to you)

0-1 1-2 2-3 3-4 4-5 5-6 6-7 7-8 8+

.How many days per week do you get cardiovascular (aerobic) exercise like walking, hiking, running, biking, etc.?

0-1 1-2 2-3 3-4 4-5 5-6 6-7

.How many hours of sleep do you get per night?

0-1 1-2 2-3 3-4 4-5 5-6 6-7 7-8 8-10

.How many servings of fruits and/or vegetables do you have daily?

0-1 1-2 2-3 3-4 4-5 5-6 6-7

.How many glasses of water do you drink daily?

0-1 1-2 2-3 3-4 4-5 5-6 6-7 8+

.How many days per week do you take Vitamin D?

0-1 1-2 2-3 3-4 4-5 5-6 6-7

.How many days per week do you take Omega 3 oils?

0-1 1-2 2-3 3-4 4-5 5-6 6-7

.Do you have specific or written goals/plans for your life?

Yes No

.How many days per week do you do resistance exercise which specifically targets building and maintaining muscle?

0-1 1-2 2-3 3-4 4-5 5-6 6-7

.How many days per week do you stretch or deliberately get movement into your spine and extremity joints?

0-1 1-2 2-3 3-4 4-5 5-6 6-7

.Do you feel as though you need to lose unnecessary body weight?

Yes No

.Do you practice some form of daily gratitude or deep breathing or meditation or mental relaxation exercises?

Yes No