HAZELDEAN FAMILY CHIROPRACTIC

Dr. Erin McLaughlin, B.Sc., D.C. | Dr. Pierre Paradis, B.Sc., D.C.
8-484 Hazeldean Road | Kanata, ON K2L 1V4 | hazeldeanchiropractic.com | T (613) 831-9665 | F (613) 831-1865

Welcome To Our Office! Please complete all questions.

Name: _____ File #:_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Sex: M F Age: _____ Birth date: (D) ____ (M) _____ (Y) _____ Status: M S W D

Email Address: _____ Home Telephone: _____

Cellular Telephone: _____ Workplace _____

Occupation: _____ Work Telephone: _____

Spouse's Name: _____

Children's Names and Their Ages: _____

Referred by: _____

Current Health Condition

Purpose of this appointment: _____

Have you seen other doctors for this condition? Y N Doctor's Name: _____

Type of Treatment: _____ Results: _____

Has this condition occurred before? Y N How long have you had your present condition? _____

Did a particular event cause your condition? _____

Where is the pain located? _____

Please describe the pain: Sharp Dull Achy Burning Tightness Throbbing Other: _____

Are you getting pain in your: Arm Hand Head Buttocks Leg Calf Foot

Is your pain: Constant Intermittent

What aggravates your condition? _____

What relieves your condition? _____

Does the pain wake you up at night? Y N

Is your condition interfering with your: Work Daily Routine Other: _____

Please list all medications you are currently taking: _____

_____

Have you experienced any weight gain or loss that you feel is unrelated to your eating habits? Y N

Please describe: _____

Have you experienced any change in bowel or bladder function? Y N

Do you experience any of the following? Dizziness Fainting Blurred Vision Do you wear orthotics? Y N

Do you suffer from any other condition other than that which you are now consulting us? _____

_____

Past Health History

Are you aware of the circumstances of your birth? No Complications Forceps Vacuum extraction C-Section

Have you ever been diagnosed with cancer? Y N What kind? _____

Are you a smoker? Y N Date quit: _____

Surgery/Operations : _____

Broken Bones/Other: _____

Motor Vehicle Accidents ? _____

Work Related Accidents? _____

Sports Related Accidents? _____

Home Accidents? _____

Childhood Injury or Illness? _____

Other Accidents, Falls or Injuries? _____

Hospitalization (Other than above): _____

Have you had previous chiropractic care? Y N Why? _____ Where? _____

When? _____ Doctor's Name: _____ Were x-rays taken? Y N

Family History(if applicable): Cancer Heart Disease Diabetes Other: _____

If there anything else of importance that you would like to mention, please do so here: _____

_____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian's Signature: _____Date: _____

Patient or Guardian's Printed Name: _____

File #: _____

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For Office Use
Patient Name: _____
File #:_____

CONSENT TO CHIROPRACTIC CARE

It is important for you to consider the benefits, risks, and alternatives to the care options offered by your Chiropractor, and to make an informed decision about proceeding with care.

Chiropractic care includes adjustments of the spine or other joints of the body, soft-tissue techniques like stretching or trigger-point work, and exercise.

BENEFITS

Chiropractic care has been demonstrated to be effective for symptoms in the spine or other areas of the body related to nerve system function, including muscles, joints, and related soft tissues. Chiropractic care may relieve pain, including headaches and neck/back pain, altered sensation, muscle stiffness, tension, and spasm. It can also increase mobility and function, and reduce or eliminate the need for drugs or surgery.

RISKS

The risks associated with chiropractic care vary according to each patient's condition, as well as to the location and type of treatment provided, and may include:

- **Temporary worsening of symptoms** – An increase in any pre-existing pain or other symptoms typically lasts only a few hours to a few days.
- **Sprain or strain** – Typically, a muscle strain or ligament sprain will resolve itself within a few days to a few weeks with some rest, protection of the affected area, and/or other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment to the area.
- **Injury to or aggravation of a degenerated spinal disc** – A person can present to a Chiropractor with existing spinal disc degeneration or damage, of which they may not be aware due to lack of symptoms. Disc degeneration is an expected result of spinal wear and tear through accumulated small or large injuries to the spine, and also from chronic misalignment of the spine causing uneven breakdown in spinal joints. A person may not know that such a problem exists if it is not causing pain, or that such a condition is worsening if they only experience periodic neck or back problems.
  Chiropractic care is not expected to cause damage to degenerated spinal discs. However, chiropractic care, like many common daily activities, may cause aggravation of such a condition.
  The consequences of a spinal disc injury or aggravation of a pre-existing disc condition may vary with each patient. In the most severe cases, symptoms may include impaired spinal mobility, radiating pain and/or numbness/tingling into the arms or legs, impaired bladder or bowel function, and impaired arm or leg function. Referral to other healthcare providers may be necessary, and other forms of treatment such as prescription drugs or surgery may be indicated.

- **Stroke** – Blood flows to the brain through arteries passing through the neck. These arteries may become weakened or damaged over time, through arterial disease or injury. A blood clot may form in a damaged artery. All or part of that clot may break off and travel up the artery to the brain, where it can interrupt blood flow and cause a stroke.
  Some common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to a neck artery, or from a clot that already existed breaking off and travelling up to the brain.
  Chiropractic care 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 already progressing toward a stroke when that patient consulted with a Chiropractor.
  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.
  Present scientific medical evidence does not establish that chiropractic care causes either arterial damage or stroke.

ALTERNATIVES

Alternatives to chiropractic care may include consulting with other healthcare professionals such as medical doctors, physiotherapists, or massage therapists. Your Chiropractor may prescribe rest without spinal adjustments, or exercise with or without spinal adjustments.

QUESTIONS OR CONCERNS

You are encouraged to ask questions at any time regarding your chiropractic assessment and/or care. Bring any concerns you have to your Chiropractor's attention. If you are not comfortable, you may stop care at any time.
Please be involved in and responsible for your care. Inform your Chiropractor immediately of any change in your condition or health status.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I acknowledge that I have discussed with the Chiropractor the assessment of my condition and the care plan. I understand the nature of the chiropractic care to be provided to me. I have considered the risks and benefits of, as well as the alternatives to, this care.
I consent to chiropractic care as recommended to me.

Patient signature: _____ Date: _____

Patient printed name: _____

Chiropractor signature: _____ Date: _____

Chiropractor printed name: _____

File #: _____

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****Please bring this form with you to your next appointment****

Chiropractic Health Insurance

Most insurance companies provide an allowance for chiropractic care. In order to give you more information about your insurance coverage, please contact your insurance company (and your spouse's insurance company if applicable) and ask the following questions:

Patient Name: _____ Date:_____ File:_____

1. Insurance company's name?

_____

2. A. How much participation per year for chiropractic care? B. Deductible?

_____

3. What is the renewal date (ie: January 1st of each year)?

_____

Spouse Information (if applicable)

1. Insurance company's name?

_____

2. A. How much participation per year for chiropractic care? B. Deductible

_____

3. What is the renewal date (ie: January 1st of each year)?

_____