welcome

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease."
– Thomas Edison

Date _____

Confidential Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(*Please Print*)
Name _____ Sex: ❑ Female ❑ Male

Address _____ City _____

Postal Code _____ Date of Birth _____ Age _____

Home Phone _____ Work Phone _____ Cell _____

Your email _____

Employer _____ Occupation _____

Where do you prefer to receive calls? ❑ Home ❑ Work

Marital: ❑ S ❑ M ❑ D ❑ W ❑ Separated Spouse's/Parents' name _____

Names and ages of children _____
(if applicable)

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone _____

Do you have additional insurance coverage for chiropractic care? ❑ Yes ❑ No

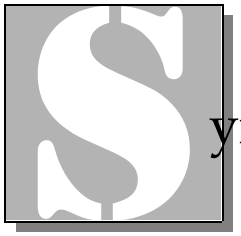
Have you ever attended another chiropractor? ❑ Yes When _____ ❑ No

Name: _____

About your Health

The human body is designed to be healthy. There are many events that occur as well as habits we develop throughout our lifetime, that interfere with our ability to maximize the expression of our optimum health potential. Please take a moment now to answer the following simple questions so that we might better understand your overall health picture. We need to develop an appreciation for the layers of damage that may exist in your body, and determine those that are contributing to the blockage of your body's innate ability to be well and healthy.

SIGNATURE _____ Date _____



ymptoms and Ill Health

As the years go by & the layers of damage increase, it is common to begin to experience symptoms and random bouts of ill health until we are brought to our present state of health.

PRESENT REASON FOR CONSULTING OUR OFFICE:

_____ Correction and prevention of existing problem?

_____ Maximizing personal and/or family health potential?

If you have a specific chief complaint, please describe it briefly.

_____

_____

How and when did this problem start? _____

_____

Does the pain radiate or travel anywhere else? ❒ Yes ❒ No
If so, where? _____

Is the problem ..... ❒ Constant ❒ Intermittent ❒ Worse with movement

Is condition worse ..... ❒ In the a.m. ❒ In the p.m. ❒ No change

Is condition interfering with ..... ❒ Sleep ❒ Work ❒ Routine ❒ Other

Is condition getting progressively worse? ❒ Yes ❒ No

Type of pain: ❒ Sharp ❒ Throbbing ❒ Numbness ❒ Aching ❒ Shooting ❒ Dull ❒ Swelling ❒ Stiffness ❒ Burning ❒ Cramps ❒ Tingling

What aggravates your condition/pain? _____
What relieves your condition/pain? _____

Have you had this problem before? ❒ Yes ❒ No
If this condition was treated in the past, please describe treatment & results.

_____

_____

Could your problem have been caused by an injury at work? If yes, please give us the details.

_____

_____

Have you had xrays taken of this area? ❒ Yes ❒ No
When? _____ Where? _____

Have you ever been involved in an automobile accident? ❒ Yes ❒ No
Date _____
Any difficulties/injuries arising from this incident? _____
_____

Please list any additional health problems you are experiencing at the present time _____
_____

Have you had any surgeries**?** ❒ Yes ❒ No
If yes, please give us a few details _____

Are you taking any medication? ❒ Yes ❒ No
If yes, please list all _____

FOR WOMEN ONLY:
Date of last menstrual period _____

SECONDARY COMPLAINTS?
_____
_____
_____

**** On a scale of 1 to 10, with 10 being the highest, rate your level of commitment in helping us solve this problem _____

Date _____ SIGNATURE _____

PATIENT AUTHORIZATION FORM

TO _____
(Name of physician, hospital or laboratory)

You are hereby authorized to provide from your records, any information or reports concerning the state of my health, which may be requested by:

David J. Matheson, DC

P: 332.8133 F: 332.4440 Email: clinic@djmatheson.com

Thank you for your cooperation. _____
(Patient's name)

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks & 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 & 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 & 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 & related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness & spasm. It can also increase mobility, improve function & 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 & 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 a 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/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. Patients 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 may also 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 the most severe cases, patient symptoms may include impaired neck or back mobility, radiating pain & numbness into the arms or legs, impaired bowel or bladder function, or impaired leg/arm function. Surgery may be needed.
- **Stroke** - Blood flows to the brain through 2 sets of arteries passing through the neck. These arteries may become weakened & damaged, either over time through aging & 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 & 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 towards a stroke when the patient consulted the chiropractor.
  Present medical & scientific evidence does NOT establish that chiropractic treatment causes either damage to an artery or stroke.
  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance & 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/without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment & treatment. Bring any concerns you have to your 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 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 & risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (please print)

_____ Date: _____ 20____
Signature of Patient (or legal guardian)

_____ Date: _____ 20____
Signature of Chiropractor