Proactive Chiropractic
Dr. Rudy Enns, DC

CONFIDENTIAL PATIENT HEALTH RECORD

Date:___________________

Name: ______________________________________

How would you like to be address?☐ First Name ☐ Mrs. ☐ Ms. ☐ Mr.
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Address: ____________________________________ City: _______________________ Postal Code:_______________

Home Phone:____________________ Birth date: ___/___/___ Age:_____ Sex: **M** **F**
MM DD YR

Work Phone: ____________________
Occupation / Student: _________________________________ Hours at work / study per week:___________________

Email:____ How did you hear about our clinic?___________________

Do you have children? ☐ YES ☐ NO Names and ages of children: ______________________________________

Previous Chiropractor: ☐ NONE ☐ Doctor's name & approximate date of last visit:___________________________

Name of physician:____

CURRENT HEALTH CONDITION

REASON FOR CONSULTING THIS CLINIC:

- ☐ I have no symptoms and I feel well. I am interested in strategies and care to help me optimize my health.
- ☐ I have a specific problem, and seek to improve function after its relief.
- ☐ Get out of pain.

Is your primary concern related to a motor vehicle accident? ☐ YES ☐ NO If yes, date of accident: _______________

What is your primary concern? _______________________________ For how long?_____________________________

Was the onset ☐ sudden or ☐ gradual ? ____

Can you localize the discomfort, or do you feel some discomfort in locations away from the chief area? _______________

____

☐ Worse ☐ Better ☐ Same ☐ Comes and goes ___ If so, what is the frequency?_____________________________

Circle one
How would you characterize the discomfort: dull, ache, sharp, stabbing, cramping, tingling, numbness, burning
How intense is the discomfort? **Least 0 1 2 3 4 5 6 7 8 9 10 most**

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Fitness/Sports ☐ Hobbies ☐ Other

What activities aggravate your condition? ____

Rate the order of aggravation: ___Sit ____ Stand _____Walk (1-Best; 3-Worst)

What activities relieve it?____

Have you had this or a similar condition in the past? ☐ YES ☐ NO If yes, how frequently? ___________________

Past treatment for this or similar condition:
☐ Chiropractic ☐ Massage Therapy ☐ Physiotherapy ☐ Medication:_____________ ☐ Other:_______________

Have you had any previous diagnostic imaging? ☐ X-ray ☐ MRI ☐ CatScan ☐ Ultrasound ☐ EKG ☐ EEG ☐ EMG
Do you have a secondary concern? ____

What do **you** think is wrong with you? ____

How old do you feel?____________________ How long has it been since you really felt good? _______________

Habits of Lifestyle:	**Heavy**	**Moderate**	**Light**	**None**
Sleep (hrs/night:_________)	❐	❐	❐	❐
Exercise (Type:_________)	❐	❐	❐	❐
Appetite	❐	❐	❐	❐
Caffeine	❐	❐	❐	❐
Alcohol	❐	❐	❐	❐
Tobacco	❐	❐	❐	❐
Vitamins/minerals	❐	❐	❐	❐

Sleep Posture:

❐ Side ❐ Back ❐ Stomach

Age of mattress: ___________

❐ Soft ❐ Hard ❐ Water

Thickness of pillows you sleep with under your head?_____________
____

Drugs and supplements you now take:

❐ Blood pressure pills ❐ Insulin ❐ Muscle relaxants ❐ Tranquilizers

❐ Pain killers ❐ Birth control ❐ Vitamins / minerals: ______________________________

❐ Recreational drugs:_____________ ❐ Others:_________________________________

Any recent weight change? ❐ ↑ ❐ ↓ Reason:____

Do you consider your diet to be good? ❐ Yes ❐ No

Daily approximation: fruits/veggies:_____% protein:_____% fat:_____% starches/baked goods:______________

PAST HEALTH HISTORY

Have you ever been in an auto accident: ❐ Past year ❐ Past 5 years ❐ Over 5 years ❐ Never

Describe:____

Hospitalizations: ____

Accidents / falls / other physical or emotional trauma:_____________________________________

Date of last physical examination:_____________________________

Would you like your physician to be informed about the services provided for you at this clinic?

❐ Yes ❐ No Address:____

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD: C – Current ; P – Past

Musculo-skeletal

C P
- ❒ ❒ Neck pain/stiffness
- ❒ ❒ Upper back pain/stiffness
- ❒ ❒ Mid-back pain/stiffness
- ❒ ❒ Lower back pain/stiffness
- ❒ ❒ Shoulders; left / right
- ❒ ❒ Arm pain; left / right
- ❒ ❒ Lower leg; left / right
- ❒ ❒ Difficulty chewing
- ❒ ❒ Clicking jaw
- ❒ ❒ Sudden weakness Where?_______________
- ❒ ❒ Walking problems
- ❒ ❒ General stiffness
- ❒ ❒ Other:_______________

Nervous system
- ❒ ❒ Nervousness
- ❒ ❒ Numbness: where?__________
- ❒ ❒ Paralysis
- ❒ ❒ Dizziness
- ❒ ❒ Confusion
- ❒ ❒ Fainting / drop attacks
- ❒ ❒ Convulsions / seizures
- ❒ ❒ Cold/tingling extremities
- ❒ ❒ Tremors
- ❒ ❒ Sweats
- ❒ ❒ Difficulty balancing
- ❒ ❒ Pins and needles sensation: Where?_______________

General
- ❒ ❒ Fatigue
- ❒ ❒ Change in energy ❒↑❒↓
- ❒ ❒ Chills
- ❒ ❒ Increased stress
- ❒ ❒ Allergies: to what?________ ____________________
- ❒ ❒ Fever: how long?__________
- ❒ ❒ Headaches – type
- ❒ ❒ Forgetfulness
- ❒ ❒ Poor posture
- ❒ ❒ Depression: how long?______

Skin
- ❒ ❒ Rashes
- ❒ ❒ Skin conditions – type_______
- ❒ ❒ Bruise easily

Gastro-intestinal
- ❒ ❒ Poor/excessive appetite
- ❒ ❒ Excessive thirst
- ❒ ❒ Nausea
- ❒ ❒ Vomiting
- ❒ ❒ Diarrhea
- ❒ ❒ Constipation

C P
- ❒ ❒ Hemorrhoids
- ❒ ❒ Liver problems
- ❒ ❒ Gall bladder problems
- ❒ ❒ Ulcers
- ❒ ❒ Hernia: where?_______
- ❒ ❒ Unexplained weight change
- ❒ ❒ Abdominal cramps
- ❒ ❒ Gas/bloating after meals
- ❒ ❒ Heartburn
- ❒ ❒ Black/bloody stool
- ❒ ❒ Colitis inflammatory bowel
- ❒ ❒ Difficult digestion

Genito-urinary
- ❒ ❒ Bladder trouble
- ❒ ❒ Frequent urination
- ❒ ❒ Decreased bladder control
- ❒ ❒ Painful urination
- ❒ ❒ Discoloured urine / blood in urine

Respiratory & Cardiovascular
- ❒ ❒ Asthma
- ❒ ❒ Chest pain
- ❒ ❒ Difficulty breathing
- ❒ ❒ Wheezing
- ❒ ❒ Lung problems / congestion
- ❒ ❒ Chronic cough
- ❒ ❒ Spitting blood
- ❒ ❒ Blood pressure problems
- ❒ ❒ Irregular heartbeat
- ❒ ❒ Heart problems
- ❒ ❒ Varicose veins
- ❒ ❒ Ankle swelling
- ❒ ❒ Stroke
- ❒ ❒ Poor circulation
- ❒ ❒ Phlebitis

EENT
- ❒ ❒ Visual problems (nystagmus / diplopia)
- ❒ ❒ Dental problems
- ❒ ❒ Sore throat
- ❒ ❒ Hoarseness
- ❒ ❒ Difficulty swallowing
- ❒ ❒ Earaches / discharge
- ❒ ❒ Ringing in the ears
- ❒ ❒ Hearing problems
- ❒ ❒ Nose bleeds

Male/Female

C P
- ❒ ❒ Prostrate problems
- ❒ ❒ Sexual dysfunction
- ❒ ❒ Menstrual irregularities
- ❒ ❒ Vaginal pain / infection
- ❒ ❒ Breast pain / lumps
- ❒ ❒ Miscarriage
- ❒ ❒ Gynecological surgery
- ❒ ❒ Menopause
- ❒ ❒ Caesarian section
- ❒ ❒ Pregnant; date of last menstruation?

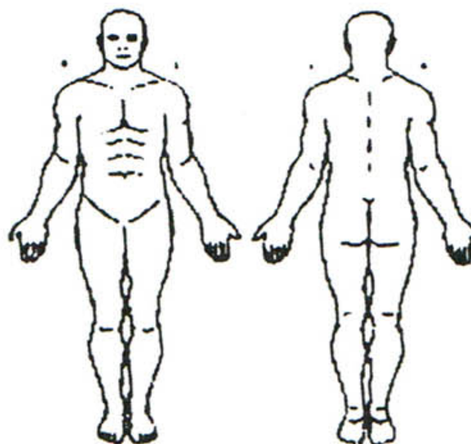
Check any of the following diagnoses you have/had:

C P
- ❒ ❒ Arthritis other______
- ❒ ❒ Rheumatoid arthritis
- ❒ ❒ Osteopenia
- ❒ ❒ Osteoporosis
- ❒ ❒ Osteoarthritis
- ❒ ❒ TB
- ❒ ❒ Diabetes
- ❒ ❒ Infection
- ❒ ❒ Other:___________

C P
- ❒ ❒ HIV + / -
- ❒ ❒ Anemia
- ❒ ❒ Cancer Type:__________
- ❒ ❒ Epilepsy
- ❒ ❒ MS
- ❒ ❒ Sciatica
- ❒ ❒ Heart disease
- ❒ ❒ Disc Herniatio

Other therapies that you utilize:
- ❒ ❒ Acupuncture
- ❒ ❒ Naturopathic Medicine
- ❒ ❒ Meditation
- ❒ ❒ Craniofacial
- ❒ ❒ Massage
- ❒ ❒ Shiatsu
- ❒ ❒ Reflexology
- ❒ ❒ Reiki

Please outline the areas of discomfort on the diagram
AAA-aching OOO-pins and needles XXX-burning
///-stabbing *-numbness**



PLEASE DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient accepted: ❒ Yes ❒ No ❒ Referred ______________________________

Informed Consent to Chiropractic Treatment

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

1. While rare, some patients have experienced rib fractures or muscle and ligament strains or sprains following spinal adjustments;
2. There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on occasion result in serious injuries resulting from cervical spinal adjustment is extremely remote;
3. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or other complications from chiropractic treatment is substantially lower than that associated with many other medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and in my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Experimental / Investigational Techniques

I, ________________________________ have been advised, and am aware that Activator, Applied Kinesiology, B.E.S.T., Contact Reflex Analysis, Craniosacral Therapy, Neuroemotional Technique and S.O.T. would be considered an experimental procedure as they are not presently taught in the core curriculum at a CCE accredited chiropractic college.

I have been advised that there are no risks associated beyond the signed consent form, which was read and signed upon my acceptance as a patient. I understand that the use of these procedures do not guarantee a "cure" of a specific condition.

I have read and accept this information and I also understand that I have a right to refuse these techniques and chiropractic care at any time.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Office Policy

I confirm that I have read and received an original copy of Proactive Chiropractic office policy.

Print Name ________________________________

My signature below confirms that I have read and agree with each of the enclosures on this page.

Signature of Patient or Guardian ________________________________

Date ________________________ Witness ________________________________

A copy of our Privacy Policy is available at the front desk for your convenience