CARLISLE FAMILY CHIROPRACTIC
Dr. David Veeneman, 1490 Centre Road, Carlisle, ON, L0R 1H2

Your Confidential Patient Information

Full Name: _____ Date: _____
Date of Birth: (dd/mm/yr.): _____ Age: _____
Address: _____ Home Phone: _____
(Town): _____ Work Phone: _____
(Postal Code): _____ Gender: ☐ M ☐ F ☐ Prefer not to answer
Email Address: _____
☐ I would ***NOT*** like to be added to your email database to receive newsletters and other relevant health information

Marital Status: ☐ S ☐ M ☐ D ☐ W
Do you have children? ☐ Y ☐ N If so, what are their ages? _____
Who may we thank for referring you to our office? _____
Name of your family physician? _____
Date & reason for your last visit: _____
Has any family member ever been diagnosed with any of the following?
☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Stroke ☐ High Blood Pressure ☐ Arthritis
Are you receiving care from additional health care providers? If so, please provide their name & specialty:
_____

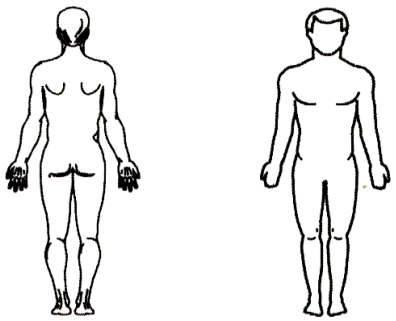
Your Present Health Concerns

What health condition(s) bring you to our office? _____
If you are here for HEALTH OPTIMIZATION & WELLNESS and are not currently experiencing symptoms, please go to page 2
Have you received care for this problem before? ☐ Y ☐ N
If yes, please explain: _____
When did the condition(s) first begin? _____
How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury
Is this condition: ☐ Getting Worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure
What makes the problem better? _____
What makes the problem worse? _____

Please check all the descriptors that best describe what you feel in relation to your current condition:

☐ Sharp ☐ Shooting
☐ Dull ☐ Cool/Cold
☐ Achy ☐ Stiffness
☐ Burning ☐ Tightness
☐ Numbness ☐ Tension
☐ Tingling ☐ Stabbing
☐ Other: _____

On the diagram above, please DRAW where you feel the concern, pain or symptom(s) are located.



If you are experiencing pain, please rate the severity of the pain on the following scale (circle a number.)

0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Your Health Goals & Expectations from Care

What are your top 3 health goals?

1. _____
2. _____
3. _____

Your History of Chiropractic Care

Have you received chiropractic care before? ☐ Y ☐ N If yes, who? _____

What was the focus of their office? ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Holistic & Wellness ☐ Other: _____

Were you happy with the results? _____

Do you have any health concerns for other family members that you would like to discuss today?

_____

Where is STRESS affecting your Capacity for Optimal Health?

TRAUMAS: Physical Injury History

Did you have any serious falls, injuries or surgeries as a child? ☐ Y ☐ N _____

Did you have any serious falls, injuries or surgeries as an adult? ☐ Y ☐ N _____

Have you had any auto accidents? ☐ Y ☐ N _____

Do you exercise frequently? ☐ Y ☐ N What type & how often? _____

How do you normally sleep? ☐ Stomach ☐ Back ☐ Side Do you wake: ☐ Refreshed & Ready ☐ Stiff & Tired

Do you commute to work? ☐ Y ☐ N Number of hours commuting/day: _____

How many hours a day do you sit at a desk, computer or tablet? _____

TOXINS: Chemical & Environment Exposures

Please rate your CONSUMPTION of:	None		Moderate		High
Alcohol	☐	☐	☐	☐	☐
Cigarettes	☐	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐	☐
Processed Food	☐	☐	☐	☐	☐

Please list any drugs/medications/vitamins or herbs that you are taking and why: _____

_____

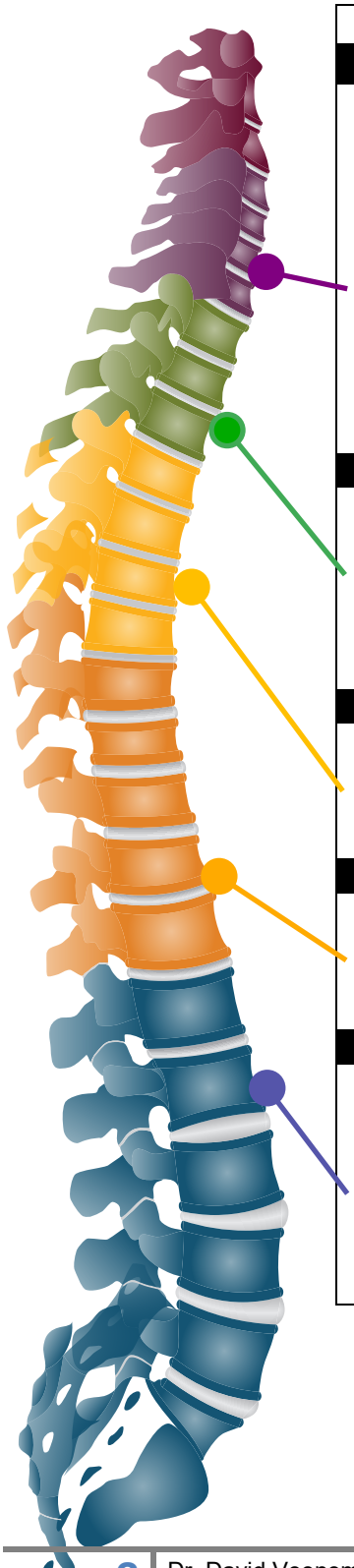
THOUGHTS: Emotional Challenges

Please rate your STRESS for:	None		Moderate		High
Home	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Life	☐	☐	☐	☐	☐
Money	☐	☐	☐	☐	☐
Health	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐

Past & Present Systems Review

Your Nervous System Controls & Coordinates All of the Organs & Structures in Your Body

Please check the corresponding box for each symptom or condition you have experienced – both past and presently.



Region	Functions	Possible Symptoms	
Cervical	Autonomic Nervous System	☐ Colic/Excessive Crying	☐ Anxiety & Stress
	ENT System	☐ Ear & Sinus Infections	☐ Depression
	Vision, Balance & Coordination	☐ Frequency Colds	☐ High Blood Pressure
	Speech	☐ Allergies & Congestion	☐ Behavioural Challenges
	Immune System	☐ Headaches & Migraines	☐ Focus & Memory Issues
	Digestive System	☐ Vertigo & Dizziness	☐ Balance & Coordination Issues
	Nerve Supply to Shoulders, Arms & Hands	☐ Swollen Tonsils/Adenoids	☐ Stiff Neck & Shoulders
	Sympathetic Nuclei	☐ Low Energy & Fatigue	☐ Poor Metabolism
	Metabolism	☐ Difficulty Sleeping	☐ Weight Control
Upper Thoracic	Upper G.I.	☐ Reflux/GERD	☐ Bronchitis & Pneumonia
	Respiratory System	☐ Chronic Colds & Cough	☐ Functional Heart Conditions
	Cardiac Function	☐ Asthma	
Mid Thoracic	Major Digestive Centre	☐ Gallbladder Pain/Issues	☐ Heartburn
		☐ Jaundice	☐ Stomach Pain & Ulcers
	Detox & Immunity	☐ Fever	☐ Blood Sugar Problems
Lower Thoracic	Stress Response	☐ Behaviour Issues	☐ Allergies & Eczema
	Filtration & Elimination	☐ Hyperactivity	☐ Skin Conditions/Rash
	Gut & Digestion	☐ Chronic Fatigue	☐ Kidney Problems
	Hormonal Control	☐ Chronic Stress	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	Lower G.I. (Absorption & Motility)	☐ Constipation & Diarrhea	☐ Sciatic & Radiating Pain
		☐ Cramps & Menstrual Issues	☐ Lumbopelvic Pain
		☐ Bladder & Urination Issues	☐ Hamstring Tightness
	Gut-Immune System	☐ Cysts & Endometriosis	☐ Disc Degeneration
		☐ Infertility	☐ Leg Weakness & Cramps
	Major Hormonal Control	☐ Impotency	☐ Poor Circulation & Cold Feet
		☐ Hemorrhoids	☐ Lower Back Pain

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Your 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 adjustments and mobilizations of the spine and other joints of the body, soft-tissue therapy, traction and other forms of therapy including, but not limited to, exercise and lifestyle advice.

There are possible risks associated with manual therapies used by Doctors of Chiropractic that vary according to each patient's condition as well as the location and type of treatment provided. These include:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.

Alternatives to chiropractic treatment may include consulting with other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

_____

Name (Please Print)

_____ Date: _____, 20____

Signature of Patient (or legal guardian)

_____ Date: _____, 20____

Signature of Chiropractor