



Fifth Avenue Place Chiropractic & Massage Therapy

WELCOME

PERSONAL INFORMATION

Thank you for choosing our practice for your chiropractic and/or massage 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: _____ AB Health # (Chiropractic Only) _____

Address: _____

City _____ Prov _____ Postal Code _____ Birth Date: _____/_____/_____ Sex: M F
Month Day Year

Home Phone # _____ Business #: _____ Cellular # _____

E-mail Address: _____ Would you like a courtesy email for future appts: Yes No

Occupation: _____ Your Employer _____

Emergency Contact: _____ Relationship: _____ Phone # _____

How did you come to find us? Internet Facebook Instagram Person: _____

Family Physician: _____ Phone: _____

SYMPTOMS

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____ Location of problem(s) _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

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

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____ Have you had this similar condition before? _____

Was the injury related to: Work accident Auto accident Date of Injury: _____

What treatment have you received for your condition? ☐ Physiotherapy ☐ Massage Therapy ☐ Acupuncture ☐ Chiropractic

Names of other doctors(s) who have treated you for this condition: _____

When did you last see a chiropractor? _____ Dr's Name: _____

Check only those conditions which are applicable

- | | | | | |
|---------------------------------------------|-----------------------------------------------|-----------------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical. Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Allergies: _____

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor ☐ Computer work

Do you smoke? ☐ Yes ☐ No How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a weekly basis? _____

Please note we would appreciate 24 hours notice to change or cancel an appointment. Your appointment time is valuable and if you are unable to make it we would like to offer that time to another patient. We do charge for missed appointments.

We maintain a high standard for the protection of the confidentiality and integrity of individual health information. If any identifying health information is to be disclosed to another party or we require information to be released to us for the purposes of providing ongoing care; express written consent will be obtained. If you have any questions regarding your privacy concerns, feel free to direct any inquiries to the front desk.

I have read and understand the above policies and procedures that are in place and agree to the terms.

I agree that a photocopy of this authorization shall be valid as the original.

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of Patient (or parent if a minor) Date _____



Fifth Avenue Place *Chiropractic & Massage Therapy*

Chiropractic ♦ Acupuncture ♦ Massage Therapy ♦ Orthotics

♦ Dr. Corey Fiske, D.C., & Associates ♦

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 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 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. 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 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 apre-existing disc condition will vary with each patient. In the 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 adamaged 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 resultingfrom damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to thebrain.

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 chiropracticreatment causes 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 healthprofessionals. 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 anytime.

**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: _____ 20____

Signature of Chiropractor

Date: _____ 20____