GLENBOURNE CHIROPRACTIC
INSPIRE WELLNESS.

Chiropractic Confidential Patient Information
Date: _____File#_____

Name: _____ Title (circle one): Mr Mrs Ms Miss Dr
First Last

Address: _____
Apt # Street & # City Postal Code

Home Phone: _____ Cell Phone: _____ Email Address: _____

Physician: _____ Clinic: _____ Health Card #: _____ Date of Birth: _____

Occupation: _____ Employer: _____ Business Phone: _____

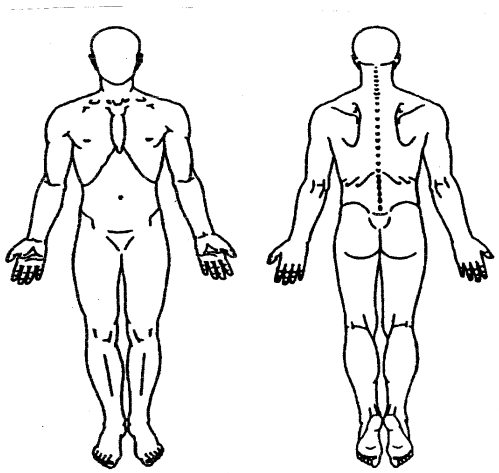
Emergency Contact: _____ Phone Number(s) _____ Relationship: _____

How did you find out about our clinic? □ Yellow Pages □ Location □ Friend _____
Friend's Name

Ever suffered an injury at work? □ No □ Yes If yes, claim# and date of accident:
Ever been in a motor vehicle accident? □ No □ Yes If yes, date of accident:

What is the main reason for consulting our clinic today? _____

_____

If you have any of the following, please indicate the location on the diagram using the symbols below: **Burning Pain = XXXX** **Sharp/Stabbing Pain = /////** **Dull/Aching Pain = ++++** **Stiffness and Tightness = SSSS** **Muscle Knots = ###** **Numbness = **** **Tingling/Pins & Needles = tttt**	

What makes it worse? _____ What makes it better? _____

Have you had this condition in the past? □ No □ Yes If yes, when? _____

Did you have x-rays for this condition? □ No □ Yes If yes, when? _____

Have you ever received chiropractic treatment? ☐ No ☐ Yes _____
(Name of Doctor or Clinic and When)

HEALTH HISTORY FORM (Please check any of the following that you currently have or have had in the past)

Cardiovascular System	**Nervous System**	**Medications**
☐ aneurysm ☐ high blood pressure/hypertension ☐ low blood pressure/hypotension ☐ heart disease ☐ stroke ☐ varicose veins ☐ phlebitis ☐ bruise easily ☐ pacemaker	☐ multiple sclerosis ☐ Parkinson's ☐ seizures/epilepsy ☐ carpal tunnel ☐ altered/loss of sensation Specify areas: _____ _____	Please indicate type, what it is for and the times that it is taken: _____ _____ _____ _____ _____ _____
Digestive Systems	**Skin**	**Respiratory Systems**
☐ ulcers ☐ constipation ☐ ulcerative colitis ☐ Crohn's disease ☐ gall stones ☐ irritable bowel syndrome (IBS) ☐ liver disease Other (specify): _____	☐ plantar warts ☐ eczema ☐ psoriasis ☐ fungal infection (ex. athlete's foot) ☐ herpes simplex Other (specify): _____ _____	☐ bronchitis ☐ asthma ☐ emphysema ☐ sinusitis ☐ chronic cough ☐ breathing problems Specify: _____ _____
Head/Neck ☐ history of headaches ☐ history of migraines ☐ vision problems or loss ☐ hearing/ear problems ☐ dizziness ***This Section For Women Only:*** ☐ *menopausal problems* ☐ *menstrual complaints* *Details:* _____ _____ ☐ *pregnant* *Due date:* _____ ☐ *Other (specify):* _____	**Other Conditions** ☐ hepatitis ☐ HIV/AIDS ☐ diabetes ☐ chronic fatigue syndrome ☐ poor/lack of sleep ☐ environmental illness ☐ allergies Specify: _____ _____ ☐ tumours/cysts ☐ cancer Specify: _____ _____ _____ Other (specify): _____	**Muscles and Joints** ☐ fibromyalgia ☐ osteoporosis ☐ arthritis Specify type and location: _____ _____ _____ ☐ pain/stiffness: ☐ head ☐ neck ☐ jaw ☐ back ☐ Lower ☐ Middle ☐ Upper ☐ arm/hand ☐ leg/foot
Other Healthcare	**Surgeries**	**Previous Injuries**
☐ physician/medical doctor ☐ chiropractor ☐ massage therapist ☐ physiotherapist ☐ naturopathic doctor ☐ nutritionist/dietician Other (specify): _____ _____	Please indicate type, area(s) and date of surgery: _____ _____ _____ _____ _____ _____ _____	Please indicate area(s), date of injury and a brief description of what happened: _____ _____ _____ _____ _____ _____

People go to chiropractors for various reasons-- some seek pain relief only, while others wish to correct the underlying cause of the problem, and prevent the problem from returning.

Please check the type of care you are seeking:

□ **Relief Care** (relief from the pain/symptoms that I am experiencing)
□ **Corrective Care** (correction of the subluxations in my spine)
□ **Preventative/Wellness Care** (optimizing my health and wellness and preventing future conditions)
□ **At the Doctors Recommendation**

If you could wave a magic wand and change 3 things <u>about your health</u> in the next year, what would the changes be?

1. _____
2. _____
3. _____

Please answer a few questions about your current lifestyle:

What is your current stress level? □ none □ mild □ moderate □ severe

How much physical activity do you get each week? □ none
□ low (1-2x /week)
□ moderate (3 – 4x/week)
□ high (5 or more x/week)

Do You Smoke? □ no □ yes If yes, how much? _____

Do You Drink Alcohol? □ no □ yes If yes, how much? _____

How Would You Rate Your Diet? □ poor □ fair □ average □ good □ excellent

PRIVACY POLICY:

The information requested will assist us in treating you safely. Privacy of your personal information is an essential part of our efforts to provide you with quality care. All staff members who come in contact with your information are trained in the appropriate uses and protection of it. Please note all information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any medical information.

_____	_____	_____
PRINT YOUR NAME	YOUR SIGNATURE (or Parent/Guardian if applicable)	DATE

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Informed Consent To Chiropractic Treatment

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary 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 complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

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 may experience short-term aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques.

2. There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.

3. There are 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.

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 my treatment in particular (including spinal adjustment) as well as contents of this Consent.

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

_____	_____	_____
Patient's Name (please print)	Patient's Signature (or signature of legal guardian)	Date