Family Chiropractic

Date: _____

Personal Information:

Full Name: _____ Date of Birth: _____

Address: _____ Town: _____ Province: _____ P/C: _____

Home Phone: _____ Work Phone: _____ Cell phone: _____

E-mail: _____ Do you have children? Aged? _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

How did you find our office? _____

Have you seen a chiropractor in the past? ❑ Yes ❑ No

If yes: Who did you see? _____ When? _____ Where you pleased with the results? ❑ Yes ❑ No

History Form:

What brought you into our office today? _____

If you are in pain, when and how did it begin? _____

_____

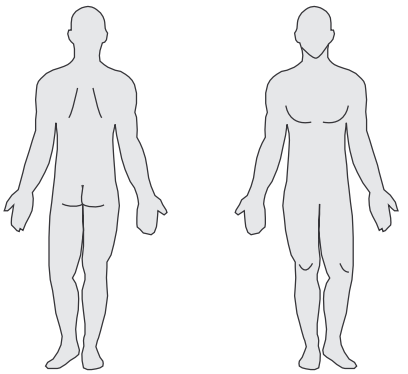
Have you had this pain before? ❑ Yes ❑ No If Yes, When _____

Please circle the severity of the pain using the following scale:

1 2 3 4 5 6 7 8 9 10

no pain extreme pain

On the diagram, please draw where you feel the concern, pain or symptom(s).



Please check the following descriptor(s) that describe what you feel in relation to your current condition:

❑ Sharp	❑ Numbness	❑ Cool/Cold
❑ Dull	❑ Tingling	❑ Stiffness
❑ Achy	❑ Stabbing	❑ Tightness
❑ Burning	❑ Shooting	❑ Tension

❑ Other _____

Does this pain radiate, travel or shoot to any other areas in your body? ❑ Yes ❑ No If yes, where? _____

Do you have any numbness or tingling in your body? ❑ Yes ❑ No If yes, where? _____

Is your complaint getting better, getting worse, or unchanged since it began? _____

Is there any daily activity that you have difficulty with or can no longer do? _____

_____

Does anything make the pain worse? ❑ Yes ❑ No If yes, what? _____

Does anything make the pain better? ❑ Yes ❑ No If yes, what? _____

What previous interventions, treatments, medications, surgery or care have you sought for this complaint?

_____

Past History:

Family Health History (for example, heart disease, diabetes, cancer): _____

_____

What previous illnesses or injuries have you had in your life? _____

_____

Do you have allergies? ❑ Yes ❑ No If yes, to what? _____

(over please)

Are you on mediation? ❑ Yes ❑ No If yes, please list:

Medication	Reason for taking

Have you had surgeries in the past? ❑ Yes ❑ No If yes, please list:

Reason for surgery	Approximate date of surgery

Social and Occupational History:

What are the physical demands of your job? _____

_____

What are your recreational activities including your physical exercise activities?_____

_____

What are your personal health goals? (For example, weight loss, cessation of smoking, physical fitness, etc.)

_____

_____

What is your level of stress right now in the following areas?

Please mark from **1 (no stress)** to **9 (very stressed)**

physical ____ mental ____ social ____ emotional ____ chemical ____

Consent to Chiropractic Adjustments/Manipulations and Management:

I hereby request and consent to the performance of chiropractic adjustments/manipulations and other chiropractic management including various modes of physical therapy and diagnostic x-rays on me by Dr. Angela VanDeWalle and/or anyone working in this clinic authorized by the doctors.

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I have had an opportunity to discuss with the Doctor of Chiropractic named above and/or with the other clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. I understand results are not guaranteed.

I understand and I am informed that, as in all health care, in the practice of chiropractic there is small risk of injury. These injuries include but are not limited to strains, sprains, disc injuries, rib fractures, as well as strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on facts known, is in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about its contents, and by signing below agree to the above procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient with a witness present.

Name (Please Print) _____Signed _____

Date _____ Witness _____

Privacy Act Acknowledgement:

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professionals Act (RHPA) and for the defense of a legal issue.

Our office will not, under any conditions, supply your insurer with your conditional medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information and we will explain the ramifications of that decision, and the process.

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code and I can ask to see the Code at any time. I agree that Family Chiropractic can collect, use and disclose personal information about

_____ as set out above in the information about the office's privacy policies.

Signed _____ Date _____ Witness _____