Chiropractic New Patient Form

The information requested below will assist us in treating you safely. Please feel free to ask any questions about the information that we require. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

If your information changes in the future, please let us know.

Name: **Today's Date:**

_____ _____

Cell Number : (_____)_____ Other Number : (_____)_____

Emergency Contact Name:_____ Emergency Contact Number:_____

Address

Street: _____

Town: _____

Postal Code: _____ _____

Province: _____

Did a health care practitioner refer you?
Yes □ No □
If Yes, Name: _____
Location: _____
If No, who referred you?

Do you have extended Health Coverage? Yes □ No □

Name of previous Chiropractor:

Email:

Name of family physician:

Occupation: **Sex: M / F**

Date of Birth: _____/_____/_____ Age: _____
M D Y

General Symptoms
□ Headache
□ Fever
□ Chills
□ Sweats
□ Fainting
□ Dizziness
□ Convulsions
□ Loss of sleep
□ Fatigue
□ Nervousness
□ Confusion
□ Depression & Anxiety

E.E.N.T
□Eye problems
□ Loss of vision
□ Ear problems
□ Hearing loss
□ Nose problems
□ Sore gums
□ Dental problems
□ Sinus problems
□ Difficulty breathing (nose)
□ Snoring
□ Hoarseness
□ Difficulty swallowing
□ Difficulty speaking

Musculoskeletal
□ Neck pain
□ Pain or numbness
Yes, Where _____
□ Low back pain
□ Swollen joints
□ Sore muscles
□ Walking problems
□ Ruptures
□ Broken Bones
□ Painful/noisy jaw

Cardio-vascular
□ Chest pain
□ Pain over heart
□ Difficulty breathing
□ Persistent cough
□ Coughing blood
□ Coughing phlegm
□ Rapid heart beat
□ Blood pressure problems
□ Lung problems
□ Varicose veins

Do you wear foot orthotics?
Yes □ No □

Genito-urinary
□ Bladder trouble
□ Excessive urination
□ Scanty urine
□ Painful urination
□ Discoloured urine

Female
□ Vaginal discharge
□ Vaginal pain
□ Unusual bleeding
□ Pelvic pain
□ Breast pain
□ Lump on breast
Are you pregnant now?
Yes □ No □

Other
# of children _____

Do you smoke?
Yes □ No □

Do you experience extreme sweating at night?
Yes □ No □

Has your vision changed lately?
Yes □ No □

Are you experiencing a sensory change on one side of your face/body? Yes □ No □

Gastro-Intestinal
□ Poor appetite
□ Excessive hunger
□ Difficulty chewing
□ Difficulty swallowing
□ Excessive thirst
□ Nausea
□ Vomiting food
□ Vomiting blood
□ Abdominal pain
□ Pelvic pain
□ Diarrhea
□ Black stool
□ Bloody stool
□ Constipation
□ Hemorrhoids
□ Liver problems
□ Gall bladder problems
□ Weight loss/gain

Please answer the following questions:

Describe what you are feeling?

Have you experienced this before? Yes □ No □

How long have you had this for?

How often do you experience this? □ Daily □ Couple of times a wk □ Randomly

What were you doing when this began?

What makes it feel better?

What makes it feel worse?

Does the pain worsen with movement? Yes □ No □

Is the pain better with rest? Yes □ No □

Does the pain awaken you at night? Yes □ No □

Please list any significant illnesses, accidents, or surgeries:

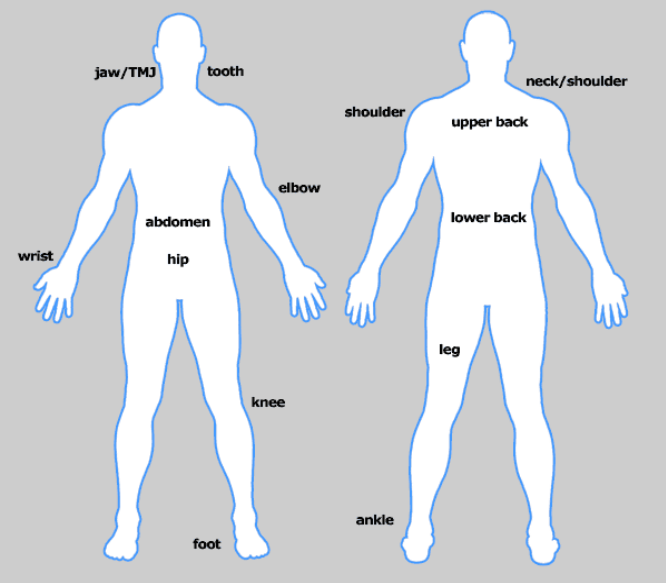
Please list any medications, and what they are taken for:

Please list any significant health concerns of other blood relatives:

Is there anything else that I should know that I have not asked?

What is your goal in coming to the clinic? (i.e. Pain relief, sport performance, increase quality of life)

Please circle your area of complaint, and indicate the type of symptom:



□ Tension
□ Tenderness
□ Stiffness
□ Muscle cramps
□ Swelling
□ Restricted movement
□ Aches
□ Stabbing
□ Numbness
□ Pins & Needles

Consent to Examine: _____(Please sign)

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
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 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 headaches, 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 only last 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 ill 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 a pre-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 a damaged 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 resulting from damage to an artery in the neck, or a clot that already exists in the artery breaking off and travelling up to the brain.

  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 chiropractic treatment 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 health professionals. 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 any time.

Please be involved in and responsible for your care. Inform you chiropractor immediately of any change in your condition.

Please initial the following boxes if you consent to the following:

☐ I agree to give Mountain Chiropractic and Natural Health **24 hours notice** should I need to cancel an appointment. I understand that if I fail to do so, I will be subject to **paying the full amount of the appointment**.

☐ I give my consent to receive periodic e-mails and newsletters from Mountain Chiropractic and Natural Health, which may include appointment reminders, schedule changes, promotions and other helpful information that we wish to share with our clients.

☐ I consent to professional collaboration of my case (RMT, Physician, Naturopath, Acupuncturist, etc.) where it would benefit my care

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
_____	_____	
Signature of Chiropractor	Date	