Chiropractic New Patient Form

The information requested below will assist us in treating you safely. All personal health information will be kept confidential unless it is released with your written consent or is required to be released by law. If your information changes in the future, please keep us updated.

Name:			**Today's Date:**
Date of Birth (dd/mm/yyyy):	**Age:**	**Sex:**	**Emergency Contact Name & Number:**
Cell Number:	**Home Number:**		**Family Physician:**
Email:			**Previous Chiropractor:**
Address: Number & Street: _____ Town & Province: _____ Postal Code: _____			Did a health care practitioner refer you? Yes □ No □ If Yes: Name: _____ Location: _____ If No: Who referred you? _____
Occupation:			Do you have extended health coverage? Yes □ No □ Insurance Company: _____

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

Cardiovascular
□ Chest pain/pain over heart
□ Difficulty breathing
□ Persistent cough
□ Coughing blood or phlegm
□ Rapid heart beat
□ Blood pressure problems
□ Lung problems
□ Varicose veins

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

Genitourinary
□ Bladder trouble
□ Excessive urination
□ Scanty urine
□ Painful urination
□ Discoloured urine

Musculoskeletal
□ Neck pain
□ Upper Back Pain
□ Lower back pain
□ Swollen joints
□ Sore muscles
□ Walking problems
□ Ruptures
□ Broken Bones
□ Painful/noisy jaw

Female
□ Vaginal discharge
□ Vaginal pain
□ Unusual bleeding
□ Pelvic pain
□ Breast pain
□ Lump on breast
Are you pregnant now?
Yes □ No □
Number of children: _____

Other

Do you smoke?
Yes □ No □

Has your vision changed lately?
Yes □ No □

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

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

Do you experience pain that wakes you up at night?
Yes □ No □

Do you have reduced bone density?
Yes □ No □

Do you wear orthotics?
Yes □ No □

Have you had any previous imaging that is related to your complaint?
Yes □ No □

Name:

Describe what you are feeling.

_____

_____

Have you experienced this before? Yes □ No □

How long ago did your symptoms start? _____

How frequently do you experience symptoms? Daily □ Weekly □ Monthly □ Randomly □

Please rate your level of discomfort: 1 2 3 4 5 6 7 8 9 10

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 □

Health History – list any significant illnesses, accidents, surgeries, etc.

_____

_____

_____

Medications & Supplements – list the name and reason for taking them.

_____

_____

Family History – list any significant health concerns of blood relatives.

_____

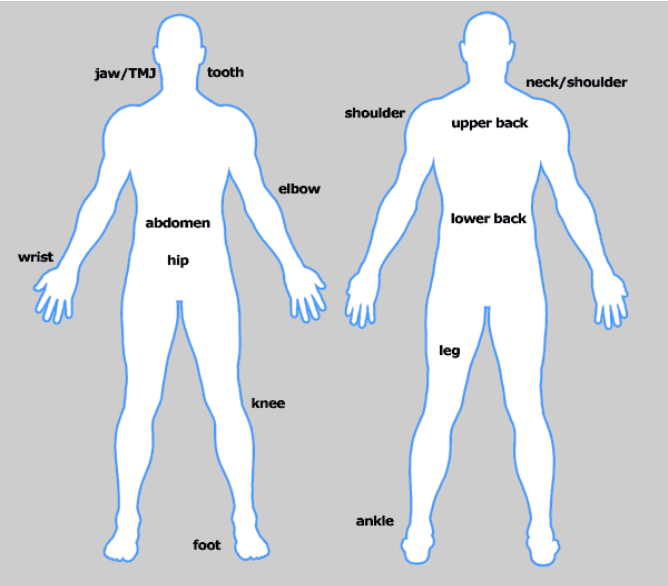
_____

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

_____

Name:

Please circle your area of complaint and indicate the character of your symptom(s):



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

What are your goals in seeking chiropractic care? (i.e. pain relief, sport performance, increase quality of life)

_____

_____

Your chiropractor will review your health history with you to ensure all information is accurate and complete. Following this, they will conduct a physical examination of your joints, muscles and nerves. This will assist in forming a working diagnosis and determining the best plan of management for your complaint. After speaking with your chiropractor, please sign below to give consent for examination.

I give consent for physical examination: _____
Patient/Guardian Signature

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

☐ I agree to give Mountain Chiropractic & 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 fee**.

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

☐ I give consent to professional collaboration of my case (Physician, RMT, Naturopath, Acupuncturist, etc.) as well as online viewing of my x-rays where it would be applicable and beneficial to my care.

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____ _____ _____
Patient/Guardian Signature Date Chiropractor Signature