**CHIROPRACTIC ASSOCIATES CLINIC**

1127 LAKEWOOD COURT NORTH, REGINA, SK S4X 3S3 ∙ PH: (306) 924-5300 ∙ FAX: (306) 924-5252

EMAIL: cac.north@accesscomm.ca

**CHIROPRACTIC INITIAL HEALTH FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| \_\_ \_\_ | \_\_ \_\_ | \_\_ \_\_ |
| MM | DD | YY |

Personal Health #: \_ \_ \_ \_ \_ \_ \_ \_ \_ Date of birth: ☐ Male ☐ Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_ Postal Code: \_ \_ \_ \_ \_ \_

Phone #: Home: ( \_ \_ \_ ) \_ \_ \_ - \_ \_ \_ \_ Work: ( \_ \_ \_ ) \_ \_ \_ - \_ \_ \_ \_ Cell: ( \_ \_ \_ ) \_ \_ \_ - \_ \_ \_ \_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*NOTE: Text messaging is used to notify patients about upcoming appointments. Would you like to receive text messages from our office?

☐ Yes ☐ No

**EMERGENCY CONTACT INFORMATION**

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: Home: ( \_ \_ \_ ) \_ \_ \_ - \_ \_ \_ \_ Cell: ( \_ \_ \_ ) \_ \_ \_ - \_ \_ \_ \_ Work: ( \_ \_ \_ ) \_ \_ \_ - \_ \_ \_ \_

Will you be claiming your Chiropractic treatment under any of the following? Please check the appropriate box.

☐ WCB ☐ SGI ☐ RCMP ☐ DVA ☐CAF

☐ Supplementary Services (Government Program)

(Senior Income Plan, Family Income Plan and Social Services)

Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: ( \_ \_ \_ ) \_ \_ \_ - \_ \_ \_ \_

Have you seen a Chiropractor before? ☐ Yes ☐ No

If so, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any imaging on the area of concern? ☐ X-ray ☐ MRI

☐ CT Scan ☐ULTRA SOUND

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where were the images taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PAST AND PRESENT MEDICAL INFORMATION**

Please **circle** any conditions that **presently** cause you problems.

Please **check** any conditions that were a problem for you in the **past**.

|  |  |  |  |
| --- | --- | --- | --- |
| **General Symptoms:**  Headache  Fever  Sweats  Fainting  Dizziness  Convulsions  Nervousness  Loss of weight  Numbness, pain, tingling | **Genitourinary:**  Poor appetite  Blood in urine  Kidney Infection  Bed wetting  Prostate trouble (men) | **Respiratory:**  Chronic cough  Spitting up phlegm  Spitting up blood  Chest pain  Difficulty breathing | **Have you recently had:**  Recent fever/infection  Unexpected weight loss  Pain waking you up at night  Night sweats  Bowel or bladder problems  Numbness or tingling  History of cancer |
| **Muscles and Joints**:  Stiff neck  Backache  Swollen joints  Painful tailbone  Foot trouble  Shoulder pain  Elbow pain  Wrist pain  Hand pain  Hip pain  Knee pain  Arthritis  Have you had any fractures?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Cardiovascular:**  Pain over heart  Stroke  Hardening of Arteries  High blood pressure  Varicose veins  Swelling of ankles  Poor circulation  Angina | **G.U. for Women:**  Painful menstruation  Excessive flow  Cramps or backache  Vaginal discharge  Swollen breasts  Lumps in breasts  Hot flashes  Number of pregnancies:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of children:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Do you currently have any of the following symptoms:**  Dizziness  Trouble swallowing  Trouble speaking  Fainting  Double vision  Unusual balance issues  Nausea  Numbness |
| **Gastrointestinal:**  Poor appetite  Indigestion  Excessive hunger  Belching (gas)  Nausea/vomiting  Vomiting with blood  Pain over stomach  Constipation  Diarrhea  Hemorrhoids  Jaundice  Gall bladder problems  Ulcer  **Please list any medications you are currently taking:**  2/4 | **Eyes, Ears, Nose, Throat:**  Failing vision  Crossed eyes  Eye pain  Deafness  Earache  Asthma  Frequency colds  Sinus infections  Enlarged glands  Enlarged thyroid | **Skin:**  Rashes  Itching  Bruises easily  Dryness  Boils | **Please list past/recent surgical procedures:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**REASON FOR VISIT**

What brings you into the office today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this complaint begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does this complaint bother you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long does it last? \_\_\_\_\_\_\_\_\_\_\_\_\_

Is there ever a time when the pain does not bother you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe the pain? (Ex: Sharp, stabbing, achy, dull). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any numbness or tingling in the arms or legs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your pain radiate down the leg or arm? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything you find relieving (ex: ice, heat, rest)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything you find aggravating (ex: standing, bending over)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received treatment/surgery for your current complaint? If so, from whom?

Has there been a change in bowel/bladder function? ☐ No ☐ Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the complaint is related to your back, is the pain mainly in the back or leg?

☐ Back Dominant.

☐ Leg Dominant.

Do you have a history of back problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have, or have you ever had, any medical conditions? (Ex: high blood pressure, high cholesterol, diabetes, cancer, heart attack, stroke, or any other medical condition or event). Please list.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any past or present medical conditions that your blood-related family members are affected by.

(Ex: high blood pressure, high cholesterol, diabetes, cancer, heart attack, stroke, or any other medical condition or event). Please list.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? If so, please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any falls, motor vehicle accidents, or other traumatic incidents?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

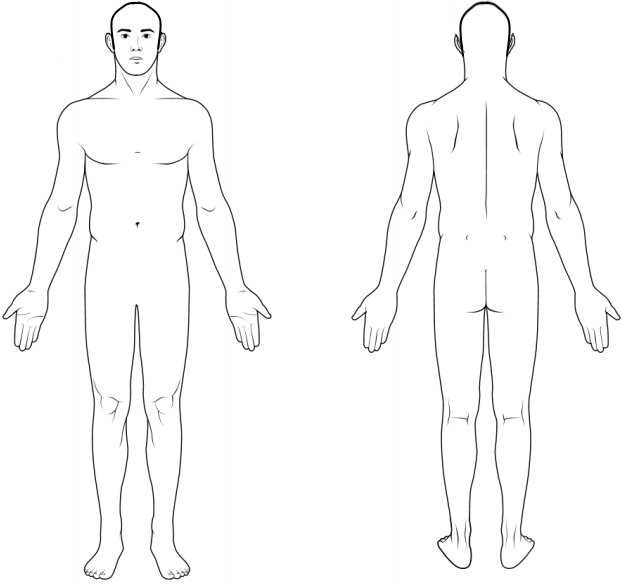
What is your height? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PAIN QUESTIONNAIRES**

**Body Pain Diagram**

Please fill this out carefully. Use the appropriate symbols (provided below) to mark the area on the diagram where you feel the described sensation. Include all affected areas, including radiation of pain.



|  |  |
| --- | --- |
| Numbness | = = = |
| Burning Pain | x x x |
| Aching Pain | ( ( ( |
| Pins & Needles | o o o |
| Stabbing Pain | / / / |

**Level of Disability**

What is the overall level of disability? (Please check the most appropriate response).

☐ No Limitations.

☐ Mild Limitations – able to do most activities with minor modifications.

☐ Moderate Limitations – able to do most activities with modifications.

☐ Severe Limitations – unable to perform most activities.

**Visual Analog Scale**

If you had to rate your pain on a scale of 0 - 10, (0 = no pain, 10 = most pain imaginable), where would you rate your pain right now? Please indicate on this scale with a check or circle.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10

*Chiropractic Associates Clinic is a multi-disciplinary clinic. If at any time you see more than one health care practitioner at this clinic, presently or in the future, do you agree to allow your health care practitioners to communicate with each other about your case?* ☐ Yes ☐ No

*If the need should arise, do you agree to allow your health care practitioners to communicate with other members of your health care team outside of this office? (i.e. General Practitioner, other specialists, etc…)*  ☐ Yes ☐ No

*I hereby certify that the above information given are true and correct as to the best of my knowledge.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature/Legal Guardian Date**

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