

**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 HEALTH UPDATE**

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

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:

Personal Health #: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_ Prov: \_\_\_\_\_\_\_\_ Postal Code: \_ \_ \_ \_ \_ \_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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*

Please note any health changes since your last visit. Add any relevant comments, even if they may already be in our records. Any additional information can be added as comments below.

|  |  |  |
| --- | --- | --- |
| **Have you had any of the following? Please check “Yes” or “No”.** | | |
| Headache? | ☐ Yes | ☐ No |
| Fainting or dizziness? | ☐ Yes | ☐ No |
| Joint pain or stiffness? | ☐ Yes | ☐ No |
| Serious infections? | ☐ Yes | ☐ No |
| Lung or breathing problems? | ☐ Yes | ☐ No |
| Angina, heart attacks, or high blood pressure? | ☐ Yes | ☐ No |
| Kidney, bladder, urinary or prostate problems? | ☐ Yes | ☐ No |
| Digestive, gall bladder, stomach or intestinal problems? | ☐ Yes | ☐ No |
| Menstrual problems? | ☐ Yes | ☐ No |
| Surgery? | ☐ Yes | ☐ No |
| Had or have been suspected of having cancer? | ☐ Yes | ☐ No |
| Been hospitalized or had any illnesses since your last visit? | ☐ Yes | ☐ No |
| Seen a doctor of anything of a more serious nature? | ☐ Yes | ☐ No |
| Had any fractures? | ☐ Yes | ☐ No |
| Fallen, or slipped and almost fallen? | ☐ Yes | ☐ No |
| Been in any automobile accidents? | ☐ Yes | ☐ No |
| Been in any workplace accidents? | ☐ Yes | ☐ No |

Briefly elaborate on the above problems. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Briefly elaborate on your present complaint. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any medications you have taken in the past year. Please circle those that you are currently taking. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Macintosh HD:Users:erinogrady:Desktop:NEW Chiro Informed Consent.pdf

