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: _____

Personal Health #: _ _ _ _ _ _ _ _ _ _ Date of birth: __ __ (MM) __ __ (DD) __ __ (YY) ☐ 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? _____

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

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:

_____

_____

_____

_____

_____

Please list any medications you are currently taking:

_____

_____

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?

_____

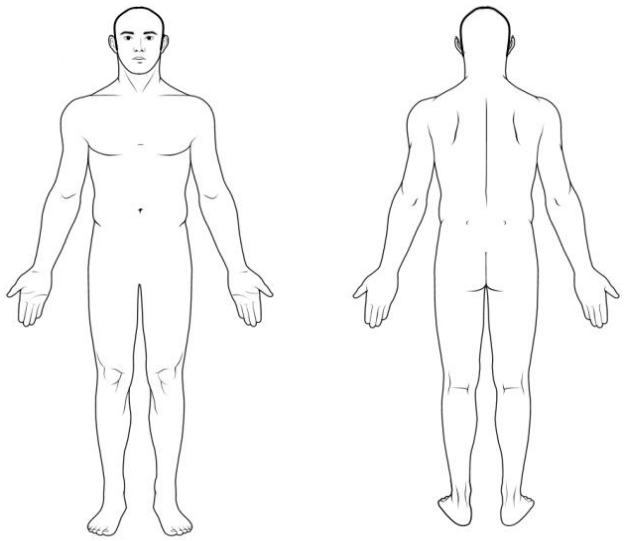
What is your height? _____ What is your weight? _____

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**

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Updated: September 2025

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