

Welcome to Adjust Your Health

Sports & family health centre

In order for the doctors to provide you with the best possible care the following confidential information must be completed.

Patients Name: _____ Date _____
Last First

Address: _____
City Postal Code

Home phone #: _____ Date of Birth _____
 Work phone # _____ Sex: M F
 Alberta Health #: _____ Marital Status: S M D W
 Occupation: _____ Email Address _____
 Employer: _____ Referred by: _____

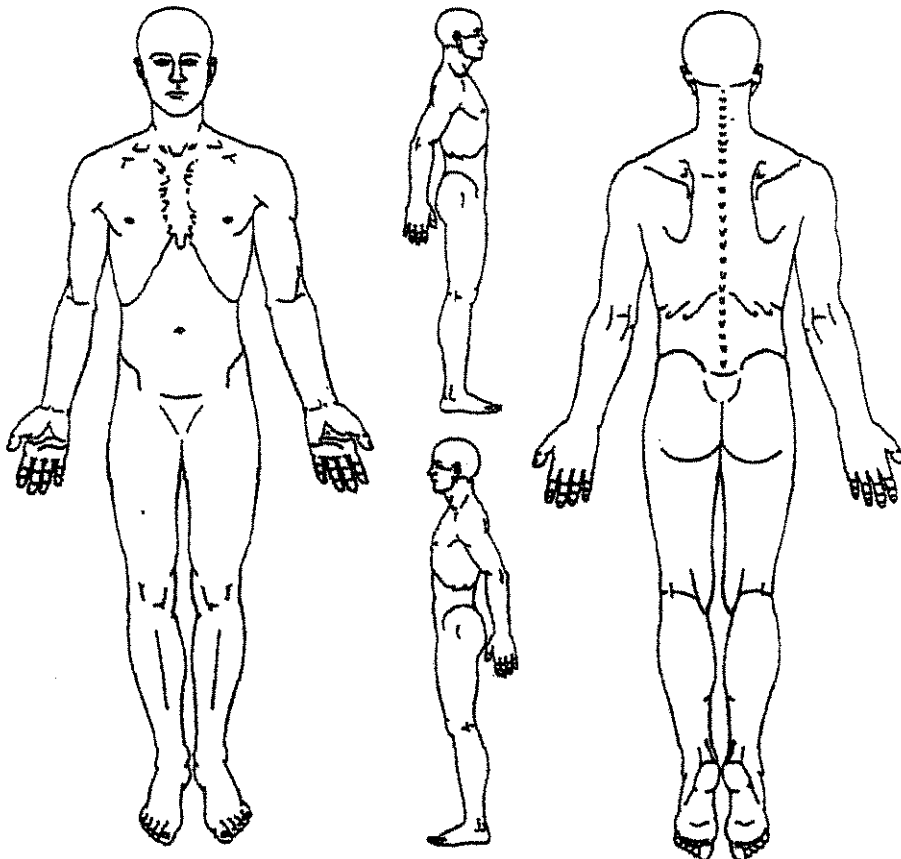
Have you ever received Chiropractic Care? Yes No

If Yes, When? _____ Who? _____

GENERAL PAIN DISABILITY INDEX

Use the letters below to indicate the type and location of your sensations right now.

A (ache) B (burning) N (numbness) P (pins & needles) S (stabbing) O (other)



What is the main problem? When did it begin? How?

Have you had this or a similar complaint before? If yes, please explain.

Does anything aggravate it? _____

Does anything make it better?

Does the complaint radiate/travel to other areas?

How severe is the pain? 0 1 2 3 4 5 6 7 8 9 10

(No pain)

(Extreme pain)

How often does the complaint occur?

How long does it last? _____

Does the complaint interfere with your: work sleep daily routine recreation (circle all that apply)

Activities/movements difficult to perform: sit stand walk bend lay down (circle all that apply)

Have you received treatment for your complaint elsewhere? If yes, please specify from the following:

 massage therapist medical doctor physiotherapist chiropractor surgeon other _____

Any other concerns or complaints? _____

Past History	Describe	date
Have you had any: Surgeries	_____	_____
Injuries	_____	_____
Auto accident	_____	_____
Hospitalizations	_____	_____
Major Illnesses	_____	_____

Are you currently taking any medications/herbs/vitamins/birthcontrol/supplements? _____

Do you have any allergies? _____

Name of your medical doctor _____

Family Medical History

Do you or a family member have a history of the following?

- | | |
|---|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Genetic disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Epilepsy | |

Lifestyle

Exercise

None

Moderate

Daily

Heavily

Work

sit

stand

light labour

heavy labour

Habits

smoke

alcohol

coffee/caffeine

high stress

packs/day_____

drinks/week_____

cups/day_____

reason_____

Some of the conditions may seem unrelated to the purpose of your appointment. However, they must be answered as these problems may affect your overall diagnosis, treatment plan and possibility of being accepted for care. Please indicate if you have experienced any of the following conditions:

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergy/ shots | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Small pox |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Measles | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tumors/growths |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Pinched nerve | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Prostate problem | |

REVIEW OF SYSTEMS

Check any of following you currently have, or have experienced in the past 6 months

GENERAL

- Nervousness
- Irritability
- Depression
- Fatigue
- Sleep disturbance
- Change in weight
- Fever

HEAD

- Headache
 - Entire head
 - Back of head
 - Forehead
 - Temples
 - Migraine
- Head trauma
- Dizziness
- Fainting
- Light headed
- Memory loss

EYES

- Change in vision
- Glasses/contacts
- Blurry vision
- Double vision
- Flashes in vision
- Spots in vision
- Sensitive to light

EARS

- Ringing in ears
- Hearing loss
- Frequent infection
- Ear pain
- Buzzing in ears
 - Drainage

NOSE

- Nosebleeds
- Sinus problems

MOUTH/JAW/THROAT

- Jaw Pain
- Change in taste
- Hoarseness
- Trouble swallowing
- Slurring speech

NECK

- Neck pain
- Stiff neck
- Grind/grate/pop sounds
- Muscle spasms
 - Masses/swelling

CHEST

- Chest pain
- Shortness of breath
- Pain around ribs
- Cough

MID BACK

- mid back pain
- pain b/w shoulder blades
- sharp stabbing pain
- muscle spasms

LOW BACK

- Low back pain (LBP)
- LBP worse with:
 - Working
 - Lifting
 - Stooping
 - Standing
 - Sitting
 - Bending
 - Coughing
 - Sneezing
- Muscle spasms
 - Masses/swelling

GI SYSTEM

- Heartburn
- Indigestion
- Gas
- Abdominal pain
- Bloating
- Nausea/vomiting
- Diarrhea
- Constipation
- Blood in stool
- Difficulty bowel control

GU SYSTEM

- Difficulty urinating
- Pain upon urination
- Blood in urine

- Change in urination
 - amount/frequency

ARMS AND HANDS

- Pain in Upper arm
- Pain in forearms
- Pain in hands
- Pain in fingers
- Sensation of pins and needles
 - in arms
 - Sensation of pins and needles
 - in fingers
- Numbness in fingers
- Cold hands/fingers
- Swollen joints
- Sore joints
- Loss of strength

HIPS/LEGS/FEET

- Pain in buttocks
- Pain in hip joint
- Pain down leg
- Pain down both legs
- Leg cramps
- Pins and needle sensation in
 - legs
 - Numbness in legs
 - Numbness in feet
 - Numbness in toes
- Cold feet
- Cramps in feet
- Swollen ankles
- Swollen feet
- Painful joint in toes
- Painful knee joint

WOMEN ONLY

- Irregular periods
- Menstrual cramps
- PMS
- Menstrual migraine
- Hot flashes
- Menopause
- Lumps in breast
- Nipple discharge

INFORMED CONSENT FORM

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments/manipulation are required to advise patients that there may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients have experienced rib fractures, muscle strains, or ligament sprains following spinal adjustments/manipulation.
- b) There have been reported cases of injury to a vertebral artery following cervical spine adjustments/manipulation. Vertebral artery injuries have been known to cause stroke or serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment/manipulation is extremely remote. (A paper published in the Canadian Medical Association Journal (CMAJ) by Scott Haldeman, CD, MD, PhD, et al. reports that the chances of arterial dissection after cervical manipulation is approximately 1 in 5.85 million manipulations. (Haldeman S, Carey P, Townsend M, Papadopoulos C. Arterial dissections following cervical manipulation: the chiropractic experience. MCAJ 2001; 165(7): 905-6))
- c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments/manipulation although no scientific study has ever demonstrated such an injury is caused, or may be caused, by spinal adjustments/manipulation or chiropractic treatment.

Chiropractic treatment, including spinal adjustment/manipulation, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall health. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

In addition to chiropractic care, I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, moxibustion, electro-acupuncture, and other techniques within the scope of practice of acupuncturists. These procedures will be performed by the doctor of chiropractic/acupuncturist, and will be discussed prior to the treatment.

I have been advised that all insertion needles are pre-sterilized and disposable. I further understand and I am informed that, as with all health care, the practice of acupuncture poses slight risks from treatment, including but not limited to temporary soreness, bruising, nausea, fainting, and bleeding. I do not expect the doctor/acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the doctor/acupuncturist to exercise judgment during the course of the procedures which he/she feels at the time, based upon facts known, are in my best interest.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic and acupuncture treatment in general and my treatment in particular, including spinal adjustment/manipulation, as well as the contents of this Consent.

I consent to the chiropractic/acupuncture treatments offered or recommended to me by my chiropractor. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PRINT PATIENT'S NAME

SIGNATURE OF PATIENT (OR PARENT / GUARDIAN)

DATE

WITNESS / VERIFICATION OF SIGNATURE