

# PERSONAL HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help determine if Chiropractic can help you. Please answer ALL questions, even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unaware of. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name: \_\_\_\_\_ Date \_\_\_\_\_ Case# \_\_\_\_\_

Health Ins. No. \_\_\_\_\_ Phone: Home \_\_\_\_\_ Office \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Marital Status \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Children \_\_\_\_\_

Birthdate \_\_\_\_\_ Birthplace \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Family M.D. \_\_\_\_\_

Referred to this office by \_\_\_\_\_

Who is responsible for your bill?  Self  Spouse  Parent or Guardian  Other \_\_\_\_\_

Insurance other than AHC? (London Life, Great West, Blue Cross, etc.) \_\_\_\_\_

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## CURRENT HEALTH CONDITION

Present complaint \_\_\_\_\_

Have you had any previous treatment for this condition? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

What do you believe caused this condition? \_\_\_\_\_

Are there others in your family with this same condition? \_\_\_\_\_

Have you had any time loss from work for this condition? (If recent list dates) \_\_\_\_\_

Is this a WCB Case? \_\_\_\_\_ If Yes - Social Insurance # & date of accident \_\_\_\_\_

Are you presently taking medication? (please mention) \_\_\_\_\_

When is the last time you really felt well? \_\_\_\_\_

How important is your health to you on a scale of 1-10, 10 being most important? \_\_\_\_\_

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## PAST HEALTH HISTORY

Major surgery/operations:  Appendix  Tonsils  Gall Bladder  Hernia  
 Heart  Back  Neck  Leg  Other \_\_\_\_\_

Major accidents or falls: (please describe) \_\_\_\_\_

Previous Chiropractic Care: Doctor's name and approximate date of last visit \_\_\_\_\_

Have you been treated for any health condition in the last year?  Yes  No

If yes, please explain \_\_\_\_\_

Check any conditions which are presently causing you a problem.  
Please underline which were a problem in the past.

**GENERAL**

- headache
- numbness or pain in arms or legs
- dizziness
- ringing in ears
- whiplash
- fainting
- earache
- sore throat
- nose bleeds
- sinus problems
- asthma
- enlarged glands
- loss of weight
- hypoglycemia
- nervousness
- depression/confusion
- vision problems
- dental problems
- hearing problems

**ORGANS**

- frequent urination
- painful urination
- blood in urine
- bladder trouble
- kidney stones
- bed wetting
- prostate problems
- sexual dysfunction
- anemia
- thyroid
- excessive appetite
- gas/bloating
- nausea or vomiting
- constipation/diarrhea
- colitis
- black/bloody stool
- hemorrhoids
- liver trouble
- gall bladder trouble

**SKIN**

- eczema
- skin eruptions
- varicose veins

**RESPIRATORY & HEART**

- lung problems
- chronic cough
- spit up blood
- frequent colds/flu
- shortness of breath/difficult breathing
- heart problems

**MUSCLE & JOINT**

- low back problems
- neck problems
- sore joints
- painful tailbone
- pain between shoulders
- spinal curvature
- arthritis
- sore muscles
- walking problems
- broken bones
- difficulty chewing/clicking jaw
- ankle swelling
- limb pain

**FEMALES ONLY**

- painful periods
- irregular cycle
- cramps, backache
- vaginal discharge/infection
- lumps/pain in breast
- menopausal symptoms
- previous miscarriage
- unable to get pregnant
- hot flashes
- are you pregnant?  
 Yes  No  Not Sure
- when was your last period?  
\_\_\_\_\_

Check any of the following diseases you have had:

- alcoholism
- venereal infection
- epilepsy
- stroke
- arthritis
- hypoglycemia
- tuberculosis
- rheumatic fever
- diabetes
- cancer
- allergies
- heart disease

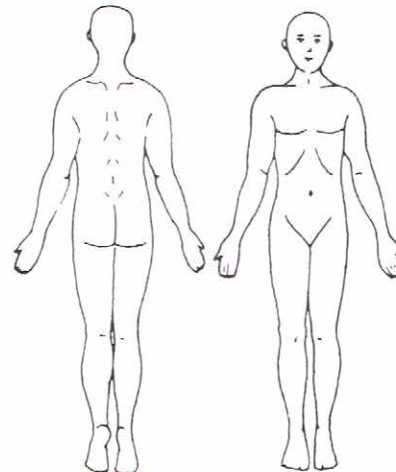
Has anyone in your family had any of the following diseases?

- heart disease
- high blood pressure
- cancer
- stroke
- arthritis

**HABITS**

	None	Light	Moderate	Heavy
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Junk Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please outline on the diagram the area of your discomfort.



**DO NOT WRITE BELOW THIS LINE — DOCTOR ONLY**

Diagnosis \_\_\_\_\_

Patient accepted:  Yes  No  Referred

Doctor's Signature \_\_\_\_\_



## CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

### Informed Consent to Chiropractic Treatment      **FORM L**

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Patient Signature (Legal Guardian)

\_\_\_\_\_  
Witness of Signature

Name: \_\_\_\_\_  
(please print)

Name: \_\_\_\_\_  
(please print)