



PERSONAL INFORMATION

Name: _____ Preferred Name: _____

Birthday: MM/DD/YYYY Age: _____ Gender: M F

Address: _____ STREET _____ CITY _____ POSTAL CODE _____

Home Ph. #: _____ Cell: _____ Work: _____

Email: _____ @ _____ BC Care Card # _____

Marital status: M D S W # of Children: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Contact Number: _____

How did you hear about this clinic: Internet Current Patient/Friend/Coworker: _____

ACCIDENT INFORMATION

Is your condition due to an accident? No Yes

If yes to whom have you reported the Accident? ICBC WCB Employer Other: _____

MAIN HEALTH CONCERNS

My usual health is: Excellent Good Fair Poor

Please list, in order of importance, your chief concerns:

1.
2.
3.
4.
5.

Goals for My Care

- I have a specific concern and require help only with this concern
- I want to ensure that my health concerns do not become an ongoing problem that will impact my future
- I want to be healthier in 5 years from now than I am today

Patient Intake Form

Give a brief detailed description of the problem you are currently experiencing: _____

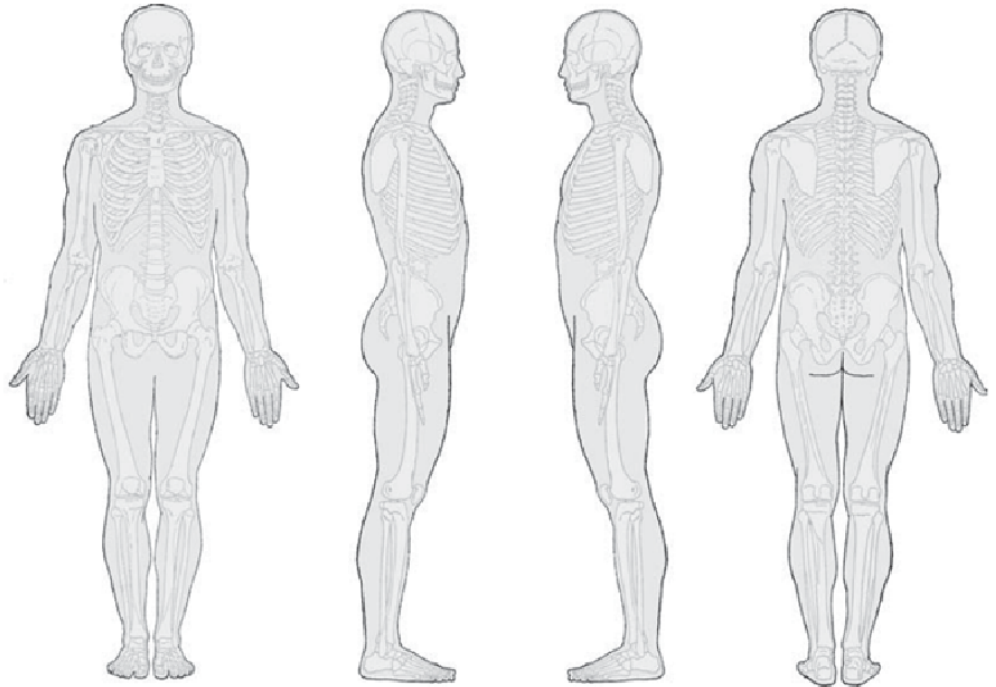
How long have you had this condition? _____ Is it getting worse? yes, no _____

Does it bother you (check appropriate box): work, sleep, other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____

How is most of your day spent? standing, sitting, other: _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	<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"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease |

Do you have any other health issues or concerns that our staff should be made aware of? _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment provided by chiropractors, 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 chiropractic treatment. Although uncommon rib fractures have also been known to occur following certain spinal adjustments;
- b) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment;
- c) 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 indicate 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 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;

Chiropractic treatment, and in particular spinal adjustments, been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain, numbness, muscle spasm loss of mobility, headaches and other related symptoms. Chiropractic care contributes to your overall well being. ***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.***

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 adjustments), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the treatments offered or recommended to me by my chiropractor, including spinal adjustments and soft tissue manipulation.

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

Printed Name

Printed Name