River North Family Chiropractic **PATIENT INTAKE FORM**

WELCOME TO OUR OFFICE

PERSONAL INFORMATION: **Today's Date:**______________

Name:___________________________________ Date of Birth:______________________________

Address:_________________________________ Age:__________

City:__________ Prov:________ Postal:_______ Sex: □ M □ F

Phone (H)__________________ (B)__________ MHSC 6 Digit #:____________________________

Email:___________________________________ MHSC 9 Digit #:____________________________

Occupation:______________________________ Employer:________________________________

Marital Status □ Single □ Married □ Divorced □ Widowed Spouse's name:____________________

Number of Children:___________Names and Ages:____

____

PRESENT HEALTH HISTORY:

Please give a brief description of the problem you are currently experiencing:_______________________

____

____

When did it start?________________________________ What caused it?________________________

If you have pain, is it: □ sharp □ dull □ radiating □ constant □ intermittent

□ mild □ moderate □ mod-severe □ severe

Since it began, it is: □ about the same □ variable □ getting better □ getting worse

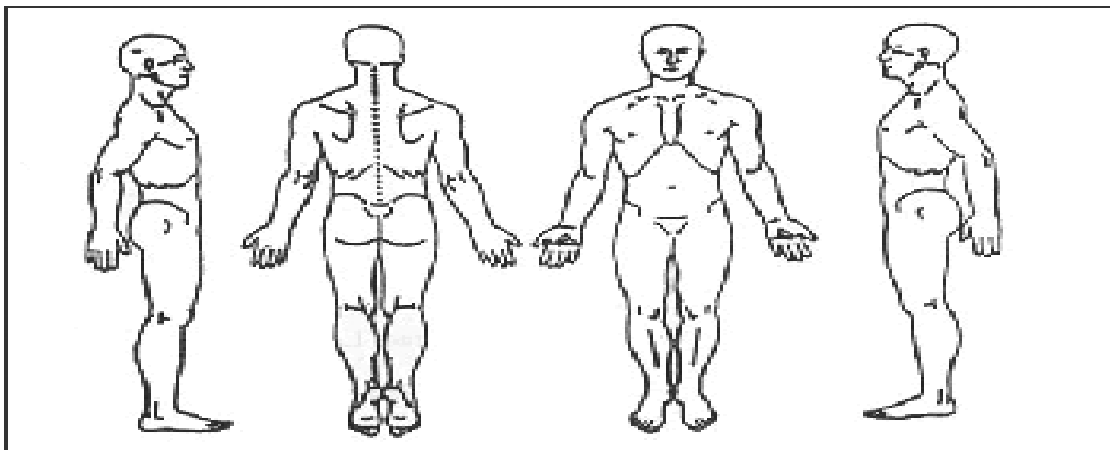
What time of day is it worst? □ morning □ at work □ evening □ variable

Does it affect: □ Work □ Sleep □ Sitting □ Standing □ Walking □ Exercise □ Other_______________

Have you had previous chiropractic care? □ Yes □ No Where?____________________________________

Last X-Rays and/or Scans:____

Please mark the area(s) of your pain on the diagram below



Please indicate (check) if you are presently affected by any of the following (within the last 3 months):

MUSCLE/JOINT
- □ Low back pain
- □ Mid back pain
- □ Neck pain
- □ Spinal curvature
- □ Shoulder pain
- □ Jaw/ TMJ problems
- □ Hip/Knee pain
- □ Foot trouble
- □ Arthritis/rheumatism
- □ Muscle pain
- □ Muscle weakness
- □ Faulty posture
- □ Numbness/tingling in Arms/hands, legs/feet

GENERAL
- □ Fever/chills/sweating
- □ Fainting
- □ Allergies
- □ Colds
- □ Recurring infections
- □ Tremors
- □ Loss of balance

EYE, EAR, NOSE, THROAT
- □ Ear ache
- □ Sore throat
- □ Sinus trouble
- □ Glaucoma

STRESS SYMPTOMS
- □ Headache/migraine
- □ Dizziness
- □ Ringing in ears
- □ Blurry vision
- □ Loss of sleep
- □ Loss of concentration/ Memory
- □ Irritability
- □ Nervousness
- □ Depression
- □ Fatigue
- □ Tension
- □ Weight loss/gain

RESPIRATORY
- □ Chest pain
- □ Chronic cough
- □ Shortness of breath
- □ Spitting up phlegm/blood
- □ Wheezing

FEMALES ONLY
- □ Painful menstruation
- □ Irregular menstruation

Last period:_______________

Do you take birth control? Y/N

Are you pregnant? Y/N

- □ Menopause

GASTROINTESTINAL
- □ Difficult digestion
- □ Belching or gas
- □ Nausea or vomiting
- □ Pain over stomach
- □ Liver trouble
- □ Gall bladder trouble
- □ Bowel/colon trouble
- □ Constipation
- □ Diarrhea
- □ Blood in stool
- □ Heartburn/reflux

CARDIOVASCULAR
- □ High blood pressure
- □ Low blood pressure
- □ Irregular heart beat
- □ Pain over heart
- □ Palpitations
- □ Previous heart attack
- □ Previous stroke
- □ Poor circulation
- □ Swelling of ankles
- □ Hardening of arteries

URINARY
- □ Painful urination
- □ Urgency to urinate
- □ Kidney stones
- □ Blood in urine

PAST HEALTH HISTORY:

Please list any significant illnesses, operations, accidents, falls, or traumas below:

Date	Illness, operation, Accident, fall, trauma

Have you... If yes, please explain

Been hospitalized within the last 5 years? □ Yes □ No ____________________________________

Had any broken bones? □ Yes □ No ____________________________________

Had any sprains/strains □ Yes □ No ____________________________________

Please indicate (check) if you have ever suffered from any of the following conditions:

□ Alcoholism
□ Anemia
□ Appendicitis
□ Asthma
□ Bronchitis
□ Cancer
□ Diabetes
□ Eczema
□ Edema
□ Emphysema
□ Epilepsy
□ Gout
□ Heartburn/reflux
□ Heart disease
□ Hepatitis
□High cholesterol
□ HIV/AIDS
□ Influenza
□ Measles
□ Miscarriage
□ Multiple Sclerosis
□ Pacemaker
□ Osteoporosis
□ Pneumonia
□ Polio
□ Stroke
□ Thyroid disease
□ Tonsillitis
□ Tuberculosis
□Ulcers

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

□ Alcoholism
□ Anemia
□ Arteriosclerosis
□ Arthritis
□ Asthma
□ Bleeding disorders
□ Cancer
□ Diabetes
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Heart disease
□ High blood pressure
□ High cholesterol
□ Kidney disease
□ Multiple sclerosis
□ Osteoporosis
□ Stroke

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

____

As a result of my chiropractic care I would like to: (Please check all that apply)

□ Feel better quickly
□ Have a healthier spine
□ Have a healthier body
□ Live a healthier, more active lifestyle

The above stated is true. I clearly understand and agree that all services rendered to me that are not covered by Manitoba Health, WCB, or MPI are charged directly to me and that I am responsible for payment when services are rendered. I also understand that if I suspend or discontinue my care and treatment, any fees for professional services rendered to me will be immediately due and payable

______________________________ ______________________

Patient Signature Date Signed

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)**

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