IMPACT
Chiropractic and Rehabilitation Centre

Confidential Patient History

Patient Information

Last Name (Mr./Mrs./Ms.) _____ First Name _____ Date of Birth(YYMMDD) _____

Address _____ City/Province _____ Postal Code _____

Home Phone _____ Alternate Phone _____ Email _____

Emergency Contact _____ Phone _____ Symptoms Began (YYMMDD) _____

Employer _____ Occupation _____ Who may we thank for the referral? _____

What brings you here today? (please circle) **Motor Vehicle Accident** **Injury** **WSIB** **Other**

Family Physician

Last Name _____ First Name _____ Specialty _____

Address _____ City/Province _____ Postal Code _____

Office Phone _____ Office Fax _____ Office Email _____

Insurance Information

Insurance Company _____ Insurance Adjuster _____ Date of Injury _____

Address _____ City/Province _____ Postal Code _____

Phone _____ Fax _____ Email _____

Group Number _____ Policy Number _____ Claim Number *(if applicable eg WSIB)* _____

Relationship to insured if not self
□ Spouse □ Child □ Other
Name _____ Date of Birth _____ Employer _____

Attorney Information (For MVA patients only)

Law Firm _____ Name of Lawyer _____ Date of Accident _____

Address _____ City/Province _____ Postal Code _____

Phone _____ Fax _____ Email _____

Group Number _____ Policy Number _____ Claim Number _____

Relationship to insured if not self
□ Spouse □ Child □ Other
Name _____ Date of Birth _____ Employer _____

6941 Derry Road, Milton, Ontario L9T-7H5 TEL: 905-875-4393 FAX: 905-875-9946
www.impactchiropractic.com

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Medical History

Chief Complaint

What brings you to the office? _____

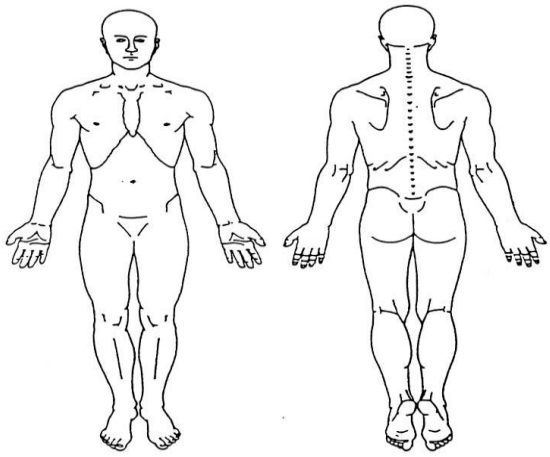
Present Ailment

Onset: What was the date of the injury? Or when did you first become aware of the symptoms? _____

Mechanism: How did the injury occur? _____

Recurrence: Have you had this pain before? ☐ YES ☐ NO Describe: _____

Location: Mark the areas on the diagram where you feel discomfort.



Radiation: Do the symptoms radiate into the arms or legs? ☐ YES ☐ NO

Quality: Describe the pain:

☐ Sharp	☐ Shooting	☐ Throbbing	☐ Stiffness	☐ Dull	☐ Aching
☐ Burning	☐ Tingling	☐ Numbness	☐ Cramps	☐ Swelling	☐ Other

Severity: Please mark a line on the scale to describer your level of discomfort. If you are describing more than one symptom, indicate the level of pain for each.

No Pain |———————————————————| **Worst Possible Pain**

Duration: How long do the symptoms last? _____ **Frequency:** How often do you experience them? _____

Temporal: Is your pain worse during any particular part of the night or day? _____

Provocative: What activities or conditions seem to make your symptoms worse? _____

Palliative: What tends to make you feel better? _____

Other Provider: Name and phone number of any other health care provider who may have treated you for this condition (including x-rays, MRI's)

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Medical History

Past Medical History

Please circle to indicate if you have had any of the following:

AIDS/HIV	Cancer	Gout	Multiple Sclerosis	Stroke
Alcoholism	Cataracts	Heart Disease	Mumps	Suicide Attempt
Anemia	Chicken Pox	Hepatitis	Osteoporosis	Thyroid Problems
Anorexia	Diabetes	Hernia	Pacemaker	Tonsillitis
Appendicitis	Drug Abuse	Herpes	Pneumonia	Tuberculosis
Arthritis	Emphysema	High Cholesterol	Polio	Tumors
Asthma	Epilepsy	Kidney Disease	Prostate Problem	Ulcers
Blood Disorders	Fractures	Liver Disease	Psychiatric Care	Vaginal Infections
Breast Lump	Glaucoma	Measles	Rheumatic Arthritis	Venereal Disease
Bronchitis	Goiter	Migraines	Rheumatic	Fever
Whooping Cough	Bulimia	Gonorrhea	Mononucleosis	Scarlet Fever

Any Surgeries? **YES** **NO**

Description	**Date**

Medications	Allergies	Vitamins/Herbals/Supplements

Family History

Please circle if you have your immediate family members that have any of the following:

Emphysema	Diabetes	Mental Illness	Osteoporosis	Arthritis
Headaches	Circulation Problems	Ulcers	Alcoholism	Cancer
Liver Disease	Heart Disease	AIDS/HIV	Back Problems	High Blood Pressure
Seizures-Convulsions	Kidney Disease	Stoke	Thyroid Disease	

Activities of Daily Life

Please rate your difficulties in performing the activities below. (0 No difficulties – 5 Cannot perform due to pain)

Difficulties with self care and personal hygiene	0	1	2	3	4	5
Difficulties with physical activities (standing/sitting/bending)	0	1	2	3	4	5
Difficulties with functional activities (lifting/pushing)	0	1	2	3	4	5
Difficulties with social or recreational activities	0	1	2	3	4	5
Difficulties with traveling (driving/flying)	0	1	2	3	4	5

Please rate how your condition has affected your senses below. (0 No change – 5 Loss of ability)

Difficulty with different forms of communication (reading/writing)	0	1	2	3	4	5
Difficulty with senses (smell/touch/taste/hearing/seeing)	0	1	2	3	4	5
Difficulty with hand function (grasping)	0	1	2	3	4	5
Difficulty with sleep and sexual function	0	1	2	3	4	5

Medical History

Review of Symptoms

Do you have or have you ever had:

• Any generalized changes in general health such as weakness, fatigue, fever, chills, night sweats, fainting, changes in sleep pattern, unexplained weight loss, unexplained weight gain or others?
YES OR NO If yes, please explain_____
• Any skin problems such as rashes, itching, dryness, sores, changes in color, changes in moles, changes in hairs, changes in fingernails or others?
YES OR NO If yes, please explain_____
• Any eye, ear, nose or throat problems such as blurred vision, double vision, eye pain, hearing loss, ringing in the ear, vertigo, sinus problems, loss of smell, hoarseness, difficulty swallowing or others?
YES OR NO If yes, please explain_____
• Any heart problems such as a murmur, palpitations, rapid heartbeat, extremity swelling, chest pain, cold extremities, high/lo blood pressure or others?
YES OR NO If yes, please explain_____
• Any lung problems such as coughing, phlegm, shortness of breath, difficulty breathing, wheezing, congestion, coughing blood or others?
YES OR NO If yes, please explain_____
• Any gastrointestinal problems such as stomach pain, nausea/vomiting, diarrhea, gas/bloating, constipation, rectal bleeding, changes in appetite/thirst, changes in stools or other?
YES OR NO If yes, please explain_____
• Any genitourinary problems such as painful urination, blood in urine, frequent urination, incontinence, urgency, change in urine appearance or others?
YES OR NO If yes, please explain_____
• Any musculoskeletal problems such as muscle pain, muscle weakness, muscle twitching, joint stiffness, joint pain, joint swelling, hot joints or others?
YES OR NO If yes, please explain_____
• Any neurological problems such as numbness, tingling, weakness, paralysis, loss of memory, loss of sensation, difficulty with coordination, dizziness, difficulty with speech or others?
YES OR NO If yes, please explain_____
• Any psychiatric problems such as depression, anxiousness, hallucination, drug addiction, suicidal thoughts, difficulty sleeping or other?
YES OR NO If yes, please explain_____
• Any endocrine problems such as severe intolerance to heat or cold, changes in thirst, excessive sweating or others?
YES OR NO If yes, please explain_____
• Any hematological problems such as anemia, diabetes, hepatitis, autoimmune disease or others?
YES OR NO If yes, please explain_____

Is there anything else you think the doctor should know about your medical history?

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Informed Consent to Chiropractic Treatment

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

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;
There are reported cases of stoke, 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 rather, 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 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;

There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no specific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.
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.

Informed Consent to Physiotherapy Treatment

I, the undersigned, do hereby agree and give my consent for Impact Chiropractic and Rehabilitation Centre's Physiotherapist(s), to provide me with medical care and treatment that is considered necessary and proper in diagnosing and/or treating my physical condition. I acknowledge I have discussed or have the opportunity to discuss with my doctors the nature and purpose of my specific treatment and the risks and benefits involved with such treatment.

Informed Consent to Acupuncture Care

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electro acupuncture by the above-named doctor or another duly authorized doctor in the clinic. I understand and am informed that in the practice of acupuncture there are some risks to treatment, fainting, infection, shock, convulsions, possible perforation of internal organs and stuck or bent needles. I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.
Note: Female Patients: I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there a possibility that I may be pregnant.

Consent for Personal Information

I understand that to provide me with Chiropractic, Acupuncture and Physiotherapy goods and services, Impact Chiropractic and Rehabilitation Centre will collect some personal information about me (e.g. telephone number, address, insurance coverage).

I have reviewed the Impact Chiropractic and Rehabilitation Centre's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.
I understand the fee schedule, and that payment is due when services are rendered along with any other statements pertaining to pay schedules.

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

I intend this consent to apply to all my present and future Chiropractic, Acupuncture & Physiotherapy.

Dated this_____day of _____, 20_____.

_____ _____

Patient Signature (Legal Guardian) Witness of Signature

Name: _____ Name: _____

Please Print Please Print

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