Cloverdale Chiropractic Clinic
your body matters

Name:_____ Date of Birth: ___/___/_____ Male ☐ Female ☐

Address_____Apt./Unit#_____

City:_____ Province_____ Postal Code:_____

Phone# Home (_____)_____Cell (___)_____ Bus (___)_____

Occupation:_____

Email Address :_____(we respect the privacy of our patients, emails are for office information and correspondence only)

Check one: Single__Married__Widowed__Divorced__Separated__

Spouse's Name_____ # of children: _____

Who may we thank for referring you to us?_____

People go to Chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to correct the underlying cause of the problem, to increase their health potential and prevent the problem from returning. Please check the type of care you are seeking:

Correction_____ Relief Care_____ Wellness_____

YOUR HEALTH PROFILE

Please briefly describe what brings you into our office today:_____

_____

Severity of symptoms - Scale 1-10 (1 being mild)_____Symptoms are: Constant____ Intermittent_____

When and how did this start?_____

Since the problem started it is – The same_____ Getting Better_____ Getting Worse_____

What makes the problem worse?_____

What if anything makes the problem feel better?_____

Who have you seen for this condition? Chiropractor_____ M.D._____ Physio _____ Other_____

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Name(s) and approximately when?_____

Over the past 90 days has the pain or dysfunction limited your ability to:

Lift heavy objects___ Stand___ Sit___ Walk __ Drive ___ Socialize___ Exercise/Sports _____

Have you had this or similar conditions before? Yes____, When? _____

How long has it been since you really felt good? _____

MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW

GENERAL HEALTH HISTORY

Please list all current and past significant health conditions, diseases and injuries, as well as past surgeries_____

_____

Have you had chiropractic care in the past? Yes____ No____ If yes, when /where_____

For what condition?_____ Were x-rays taken? Yes_____ No _____

Your Medical Doctor's name:_____ Date of last Physical Examination_____

List any medications you are currently taking, and why _____

_____

Have you ever been hospitalized? Explain _____

Have you ever been knocked unconscious? Yes __ No __Don't Know__, If yes, for how long?_____

Have you ever been in an automobile accident? Explain _____

Women: Are you pregnant? Yes__ No __ Not sure__ Type of birth control used_____

AN IMPORTANT COMPONENT OF CARE IS REGULAR REASSESSMENT, PLEASE RATE THE FOLLOWING:

Your overall quality of life	low 1 2 3 4 5 6 7 8 9 10 high
Your mood	low 1 2 3 4 5 6 7 8 9 10 high
Your energy	low 1 2 3 4 5 6 7 8 9 10 high

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Your ability to move low 1 2 3 4 5 6 7 8 9 10 high

Your ability to do household activities low 1 2 3 4 5 6 7 8 9 10 high

Your ability to do recreational activities low 1 2 3 4 5 6 7 8 9 10 high

YOUR STRESS PROFILE

1. **PHYSICAL STRESSES**

Have you had work related injuries? Yes___ Briefly explain _____

Have you had sports related injuries? Yes ___ Briefly explain _____

Have you had slips, falls or auto accidents? Yes _____ Briefly explain _____

2. **EMOTIONAL PSYCHOLOGICAL STRESSES** On a scale of 1 t0 10 (1 is low, 10 is extreme)
   ___/10 Occupational/School stresses: explain_____
   ___/10 Family/Relationship stresses: explain_____
   ___/10 Other stresses (ie. Financial): explain_____

3. **NUTRITIONAL CHEMICAL STRESSES** On a scale of 1 to 10 (1 is poor, 10 is excellent)
   Water___/10, Proteins ___/10, Healthy Fats ___/10, Fruits/Vegetables ___/10
   Is your diet high in: sugar __ Unhealthy snacks___ Soda ___ Processed foods ___ Coffee __

Which of the following supplements do you take regularly: Omega 3 ___ Vit. D___ Probiotics ___

Do you wear orthotics: YES ☐ NO ☐ If yes, _____ arch lifts ____ support

List other supplements you take regularly _____ _____

Rate the following: On a scale of 1 to 10 (1 is poor, 10 is excellent)

Exercise__/10 Sleep__/10 Positive Attitude__/10 Wellness lifestyle __/10

Please let us know if there are any health related issues that concern you, aside from the main problem that you are coming here for_____

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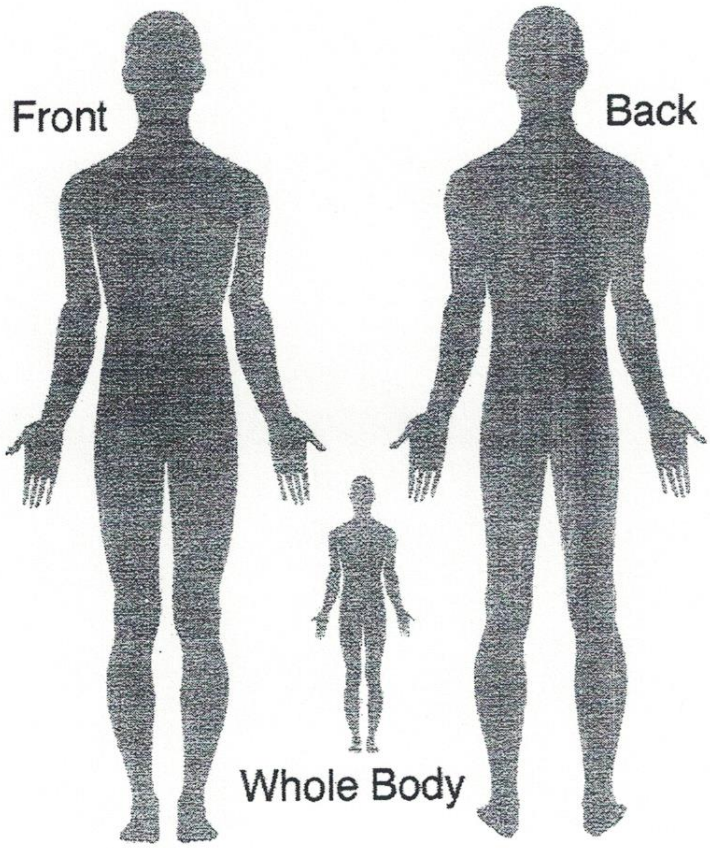
FAMILY HISTORY:

Many health problems are the result of hereditary spinal weaknesses, thus, information about your family members will give us a better picture of your total health. Please list any family member who has or had any health problems.



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)