FAMILY CHIROPRACTIC CENTRE

☐Dr. Brent Lipke
☐Dr. Frank Dallan
☐Dr. Dan Vitale

Date: _____ **CONFIDENTIAL ADULT PATIENT HEALTH RECORD**

PERSONAL INFORMATION

Whom shall we thank for referring you to our office? _____

Name_____ Address _____

City _____ Postal Code_____ Cell Phone # _____

Home Phone # _____ Birthdate: Day____ Month____ Year_____ Current Age _____

Business/Employer _____ Type of work _____

Business Phone # _____ Email Address _____

I would like an email reminder sent for my regular appointments. **Yes** ◯ **No** ◯

Emergency Contact _____ Phone # _____ Relationship? _____

Spouse/Partner's Name_____ Number of children_____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? ☐Yes ☐No Date of last visit: _____

What are your health goals? ☐Symptom relief (Temporary) ☐Wellness Care (Long term) ☐100% Optimal potential

YOUR HEALTH PROFILE

Why This Form is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, thermal and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and not even felt until they become serious. Please, answer every question.

The Beginning Years (to age 17)

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Did you …	YES	NO	UNSURE
Have any childhood illnesses?	◯	◯	◯
Have any serious falls as a child?	◯	◯	◯
Play youth sports?	◯	◯	◯
Take/use drugs?	◯	◯	◯
Have any surgery?	◯	◯	◯
Have you fallen/jumped from a height over 3 feet? (i.e. crib, bunk bed, tree)	◯	◯	◯
Were you involved in any car accidents as a child?	◯	◯	◯

	YES	NO	UNSURE
Did you suffer any other physical traumas?	◯	◯	◯
Was there any prolonged use of medicine such as antibiotics or an inhaler?	◯	◯	◯
As a child, were you under regular Chiropractic care?	◯	◯	◯

Were you delivered: ◯Naturally ◯C-Section ◯Forceps ◯Vaccuum ◯Mother was induced ◯Unsure

Adult Years (Age 18 to present)

	YES	NO
Do/did you smoke?	◯	◯
Have you been in any accidents?	◯	◯
° If so, was your nerve system checked by a Chiropractor afterwards?	◯	◯
Have you had surgery?	◯	◯
° If so, for what?		

Do/did you…	YES	NO
Participate in extreme sports?	◯	◯
Play contact sports?	◯	◯
° If so did you have your spine and nerve system checked regularly by a Chiropractor?	◯	◯

On a scale of 1-10 rate your stress levels (1=none, 10=severe)
Occupational Stress _____ Personal Stress _____

Please list any medications that you are CURRENTLY taking _____

Please turn over and complete the other side

Falls - please indicate if you have EVER experienced any of the following; include approximate date when happened and the injury sustained: down the stairs/on ice/off bikes/off chairs/off beds/off ladders/ off horses/from change table/from trees, etc.

Date of injury: What happened:

Date of injury: What happened:

Work and physical stress - please check all that apply to your work day:

◯ Prolonged Sitting ◯ Prolonged standing ◯ Computer Desk work ◯ Heavy lifting ◯ Repetitive motions ◯ Studying

Broken Bones/Stitches - please list the injuries and explain what happened

Date of injury: What happened:

Date of injury: What happened:

Sleep posture : ◯ Side ◯ Stomach ◯ Back ◯ Restless # of pillows _____ # of hours your sleep _____

Car Accidents - List ALL no matter how minor

Date: Date: Date:

For women : Are you pregnant? ◯ Yes ◯ No ◯ Trying ◯ Unsure Date of last menstrual period: _____

If you have no specific symptoms or complaints, and are here mainly for wellness services please check (✓) here _____ and skip to "Family Health Profile" (at the bottom of the next page). Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the affect it has had on your life.

WHAT IS YOUR PRIMARY HEALTH CONCERN? _____

On a scale of 1-10 (10 being severe), how bad is this problem? _____ / 10

What date did it start? _____ How did it happen? _____

Is it: ◯ Getting better ◯ Getting worse ◯ Staying the same ◯ Does the pain travel? ◯ Y ◯ N To where?_____

How would you describe the problem? Sharp, dull ache, stabbing, throbbing, burning, etc.

Are you taking medication for this condition? Y ____ N ____ Name of medication:_____

What else have you tried for this condition that has not worked? _____

Doctor's notes: _____

Please continue to the next page

Please check off **ALL** of the following you have **EVER** had even if you don't think they are related to the current problem:

◯ Stress	◯ Arthritis	◯ Allergies	◯ Nausea	◯ Osteoporosis
◯ Loss of sleep	◯ Herniated disc	◯ Asthma	◯ Ulcers / Heartburn	◯ Cancer of _____
◯ Fatigue	◯ Miscarriage(s)	◯ Chest pain	◯ Constipation	◯ Bladder trouble/Painful Urination
◯ Dizziness	◯ Depression	◯ Heart disease	◯ Diarrhea	◯ Sexual dysfunction
◯ Confusion / Forgetfulness	◯ Low back / Hip Pain	◯ Shortness of breath	◯ Pain / Stiffness in mornings	◯ Liver / Gall bladder problems
◯ Numbness / Tingling	◯ Arm / Hand Pain	◯ Heart/vascular problems	◯ Diabetes	◯ Menstrual cramping / Irregularities
◯ Pain between shoulders	◯ Foot pain	◯ Imbalances	◯ Thyroid problems	◯ TMJ(jaw trouble)
◯ Buzzing/Ringing in ears	◯ Shoulder pain	◯ Anxiety	◯ Upset stomach	◯ Sinus problems
	◯ Leg pain	◯ Walking problems	◯ Mood swings	◯ Blood pressure trouble
◯ Pinched nerve	◯ Knee pain	◯ Headaches	◯ Frequent colds	◯ Ankle swelling
◯ Chronic infections	◯ Neck pain	◯ Migraines		

Please rate your **level of commitment** to resolving this/these problem(s) (10 being the highest)

1 2 3 4 5 6 7 8 9 10

Family Health Profile

The fee for your appontment today includes an initial examination and X-rays for any immediate Family members. Please let us know below about any concerns you may have with the health and well-being of any of these members of your family.

Children:_____
Spouse: _____
Mother/Father: _____
Brother(s)/Sister(s): _____
Others: _____

Patient Signature:_____ Date _____

Transforming lives one patient at a time

www.guelphchiropractors.com

9-987 Gordon Street (corner of Gordon and Kortright), Guelph, Ontario N1G 4W3

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

FAMILY CHIROPRACTIC CENTRE

INFORMED CONSENT TO X-RAY

(to be completed on day of x-ray)

All women of childbearing age must sign this release and check the appropriate category.

"This is to certify that, to the best of my knowledge, I am not pregnant. The Chiropractor has my permission to take x-rays. I will assume all responsibility for all effect on a fetus potentially present."

☐ I am presently using the birth control pill or an IUD as a form of birth control.

☐ I have started my menstrual period within the last 10 days. Date: _____

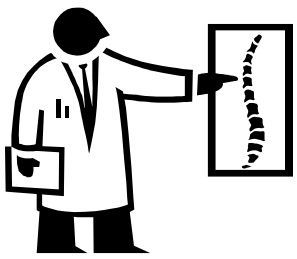
☐ I have had a hysterectomy or tubal ligation. Date _____

☐ I am presently in menopause or post-menopause.

☐ None of the above.

Name_____ Signed: _____

Date: _____ Witness:_____



987 Gordon Street, Guelph, Ontario N1G 4W3 519.837.1234 familychiropractic@rogers.com