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 _____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment Form – L

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients have experienced rib fractures or muscle ligament strains or sprains following spinal adjustments;

b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;

c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar 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 discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to having X-rays if deemed necessary to my treatment and agree to pay any additional costs incurred therein.

I accept that results are not guaranteed and that there may be some side effects associated with the wearing of prescribed orthotics.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

I consent for my chiropractor to send me an unencrypted email containing my x-rays.

Dated this _____ day of _____, 20 _____.

_____ _____

Patient Signature (Legal Guardian) Witness of Signature

Name:_____ Name:_____

(please print) (please print)

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: _____

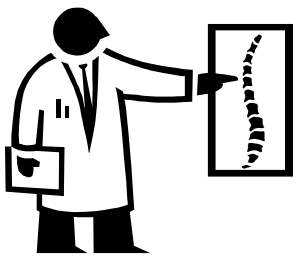
☐ I have had a hysterectomy or tubal ligation. Date _____

☐ I am presently in menopause or post-menopause.

☐ None of the above.

Name_____ Signed: _____

Date: _____ Witness:_____



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