

## **INFORMED CONSENT TO EXAMINATION & X-RAY:**

I hereby request and consent to the performance of a Chiropractic, Orthopaedic and Neurological examination and diagnostic x-rays (if required) which will determine if Chiropractic can help me. I understand that in some cases, the examination may aggravate my present condition.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(please print)

### **FOR WOMEN ONLY:**

Dat of last period? \_\_\_\_\_ Are you pregnant?  YES  NO  MAYBE

## **INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE:**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, custom foot orthotics or subsequent diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatments, including, but not limited to, muscle strains and sprains, rib fractures, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure, which to doctor feels at the time, based upon the facts then known, is in my best interests.

**I have read the above consent for chiropractic adjustments and care.**

**I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS  
CONTENT, AND BY SIGNING BELOW,  
I AGREE TO THE ABOVE NAMED PROCEDURES.**

**I intend this consent form to cover the entire course of treatment for my  
present condition and for  
any future condition(s) for which I seek treatment.**

\_\_\_\_\_  
PATIENT'S NAME (please print)

\_\_\_\_\_  
SIGNATURE OF PATIENT (or parent/guardian)

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
WITNESS TO SIGNATURE ABOVE

**Dr. Frazer D. Smith    Dr. Mark A. Czubak**  
Smiths Falls Family Chiropractic  
22 William St., W., Smiths Falls, ON K7A 1N1    (613) 283-4100

# CONFIDENTIAL PATIENT INFORMATION

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

PHONE: RES \_\_\_\_\_ BUS \_\_\_\_\_ CELL \_\_\_\_\_

EMAIL \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ POSTALCODE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_  SINGLE  MARRIED  COMMON LAW  SEP  DIV  WIDOW/ER

NO OF CHILDREN \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

OCCUPATION \_\_\_\_\_ NO. YRS. \_\_\_\_\_ EMPLOYER \_\_\_\_\_

What have you heard about chiropractic care? \_\_\_\_\_

Are you interested in a preventive approach? \_\_\_\_\_

Who may we thank for recommending our services to you? \_\_\_\_\_

## **YOUR HEALTH PROFILE**

***Why this form is important:*** We are a wellness and family oriented chiropractic office, serving Smiths Falls since 1997. We strive to help you with the health reason you have consulted us today. We offer you the opportunity towards improving your overall ability to be optimally healthy in the future as well. On a daily basis, we experience layers of physical, chemical and emotional stress that accumulate and result in serious loss of our health potential, and often illness. Usually these effects are gradual and are not painful, but they do reduce our ability to function at our best, day to day. Answering the following questions will give us a profile of the specific concerns and stresses you have faced in your lifetime. This will allow us to help you with your immediate condition, and if you wish, help you achieve a healthy strategy for the future.

## **CHILDHOOD AND ADOLESCENCE**

Research shows that many health challenges we experience have their roots during the developing years, some starting at birth. Please answer the following questions to the best of your ability.

### **CHILDHOOD**

- Did you have childhood illnesses?  YES  NO
- Did you have any serious falls as a child?  YES  NO
- Did you play youth sports?  YES  NO
- Did you take/use any drugs?  YES  NO
- Have you fallen/jumped from a height over 3 ft?  YES  NO
- Were you involved in any car accidents?  YES  NO
- Was there prolonged use of antibiotics or inhalers?  YES  NO
- Did you suffer physical or emotional trauma?  YES  NO
- Were teeth extracted or dental orthodontics used?  YES  NO
- Were you vaccinated?  YES  NO
- Were you under regular chiropractic care?  YES  NO

### **ADULT YEARS (AGE 18 TO PRESENT)**

- Do/did you smoke?  YES  NO per day \_\_\_\_\_
- Do/did you drink alcohol?  YES  NO per day \_\_\_\_\_
- Do you skip meals?  YES  NO per day \_\_\_\_\_
- Do you drink coffee?  YES  NO per day \_\_\_\_\_
- Do you spend on a computer/laptop/cellphone daily? \_\_\_\_\_ Hours per day \_\_\_\_\_
- Have you been in any accidents?  YES  NO
- Have you had any surgery?  YES  NO
- Do/did you play any adult sports?  YES  NO
- Do/did you participate in extreme sports?  YES  NO
- Do you take time for family outings/fun and holidays?  YES  NO

On a scale of 1-10 (10 being very high), describe your stress level

Occupation \_\_\_\_\_ Personal \_\_\_\_\_

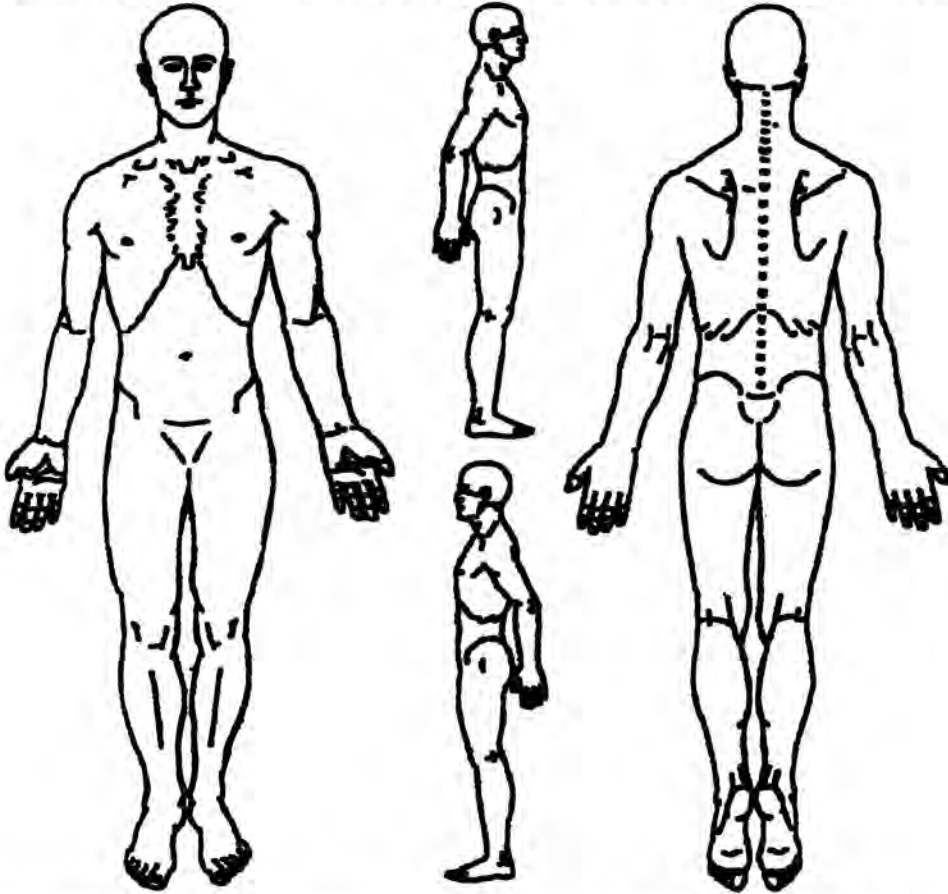
I understand that my personal information will be kept confidential according to the Regulated Health Practitioners Act and Privacy Legislation.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**If you have no complaints or symptoms, and are here for a wellness assessment, please check  .....and proceed to "Health Profile"**

Please describe the locations of your chief complaint using the key below. Chiropractic assesses the whole body, so please indicate all areas of concern, even if you think they are unrelated to your chief concern. (eg. Jaw discomfort, digestive discomfort, ear/balance trouble, wrist discomfort)



Place letters of key at your areas of concern.

KEY	
A	- ache
B	- burning
N	- numbness
P	- pins/needles
S	- stabbing
O	- other

Using the scale below, please rate your present level of ability (10 - Full ability; 0 - No ability)

1. Family	0	1	2	3	4	5	6	7	8	9	10
2. Recreation	0	1	2	3	4	5	6	7	8	9	10
3. Social Activity	0	1	2	3	4	5	6	7	8	9	10
4. Occupational	0	1	2	3	4	5	6	7	8	9	10
5. Self Care	0	1	2	3	4	5	6	7	8	9	10
6. Life Support (sleep, eating, breathing)	0	1	2	3	4	5	6	7	8	9	10

**NOTES:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

When did this condition(s) begin? \_\_\_\_\_

Has it occurred before? \_\_\_\_\_

How frequent is the complaint?  CONSTANT  DAILY  INTERMITS  NIGHT ONLY

Since it began, is it  ABOUT THE SAME  GETTING BETTER  GETTING WORSE

What makes it worse? \_\_\_\_\_

How long does it last?  ALL DAY  A FEW HOURS  MINUTES

What relieves the problem for you? (eg. rest, ice, heat, stretching, medication) \_\_\_\_\_

Is it  MILD  MODERATE  SEVERE

## HEALTH PROFILE

**Please check all categories you have ever experienced, even if you think they are unrelated to your concern**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches                           | <input type="checkbox"/> Numbness in fingers              | <input type="checkbox"/> Trouble swallowing     | <input type="checkbox"/> Pins and needles in arms        |
| <input type="checkbox"/> Fatigue                             | <input type="checkbox"/> Shortness of breath              | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Sleep problems                  |
| <input type="checkbox"/> Stiff neck                          | <input type="checkbox"/> Loss of Balance                  | <input type="checkbox"/> Jaw grinding           | <input type="checkbox"/> Neck pain                       |
| <input type="checkbox"/> Slouched posture                    | <input type="checkbox"/> Buzzing/sounds in ears           | <input type="checkbox"/> Sensitive eyes         | <input type="checkbox"/> Cold Sweats                     |
| <input type="checkbox"/> Back pain                           | <input type="checkbox"/> Bloating                         | <input type="checkbox"/> Mood swings            | <input type="checkbox"/> Menstrual pain                  |
| <input type="checkbox"/> Heartburn                           | <input type="checkbox"/> Depression                       | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcers                          |
| <input type="checkbox"/> Loss of smell                       | <input type="checkbox"/> Hot flashes                      | <input type="checkbox"/> Gastric Reflux         | <input type="checkbox"/> Loss of taste                   |
| <input type="checkbox"/> Fevers                              | <input type="checkbox"/> Tension in chest                 | <input type="checkbox"/> Cold hands             | <input type="checkbox"/> Feeling faint on rising quickly |
| <input type="checkbox"/> Cold feet                           | <input type="checkbox"/> Diarrhea                         | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Nervousness/Anxiety             |
| <input type="checkbox"/> Constipation                        | <input type="checkbox"/> Problems urinating               | <input type="checkbox"/> Separation/divorce     | <input type="checkbox"/> Pins and needles in legs        |
| <input type="checkbox"/> Bathroom visits to urinate at night | <input type="checkbox"/> Change in job status/work stress | <input type="checkbox"/> Numbness in toes       | <input type="checkbox"/> Upset stomach                   |
| <input type="checkbox"/> Recent death of a loved one         |   |   |  |

Please note any major illness you have had:

- |                                     |   |                                       |                                    |                                 |
|-------------------------------------|---|---------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Anemia       | <input type="checkbox"/> Ulcers    | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy     | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke     | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Other: _____ |                                    |                                 |

Have you ever:  Been Unconscious?  Used a cane?  Fractured a bone?  Been Hospitalized

Please list the specifics of any major accidents or surgeries \_\_\_\_\_

Please list any medical/dental/visual tests that you have received in the last 2 years

- |   |   |                                     |                                       |
|---|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Spinal Examination | <input type="checkbox"/> Physical Examination | <input type="checkbox"/> Blood Test | <input type="checkbox"/> Urine Test   |
| <input type="checkbox"/> X-ray              | <input type="checkbox"/> CT                   | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Other: _____ |

Are you taking medication for any of the following: (Tick all that apply)

- |                                       |                                      |   |                                       |   |
|---------------------------------------|--------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> Nerve/Stress | <input type="checkbox"/> Pain        | <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Pep/Energy   | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Heart        | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Blood Thinners   | <input type="checkbox"/> Other: _____ |   |

Please list the natural supplements you take \_\_\_\_\_

## YOUR FAMILY HEALTH

Our office attracts and cares for families. We are interested in how their health background may affect you, and also in their specific concerns. Please note any health concerns you have knowledge of.

Name	Relationship	Past & Present Health Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____