IMPULSE
CHIROPRACTIC AND MASSAGE

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604-951-8959

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The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods. Please complete this confidential health questionnaire fully and accurately. The more we know about the overall picture of your health, the better we will be able to help you. Doctors of Chiropractic are trained to detect and correct vertebral subluxations. Please respond to this questionnaire thoroughly, to help us determine potential causes and effects of subluxations in your case. If you have any questions please don't hesitate to ask one of our chiropractic assistants for guidance.

Patient Information **Nickname/Preferred Name :** _____

First Name: _____ **Middle Initial**: ____ **Last Name**: _____

Street Address:_____ **City**:_____ **Prov**:_____ **Postal Code**:_____

Home:_____ **Cell**:_____ **Work**:_____ **EXT**:_____

Email:_____

Care Card Number:_____ **Birthdate**: (m/d/yr) _____**Age**: ____ **Height**: ____**Weight**: ___

My Occupation:_____ **Employer**:_____

Gender: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Common Law ☐ Widowed

Name of Spouse/Significant Other:_____

Previous Chiropractic Care

Have you ever been adjusted by another Chiropractor?

☐ Yes ☐ No

If yes, Chiropractors Name:_____

Reason for seeing previous Chiropractor:_____

_____

Were X-rays taken? ☐ Yes ☐ No

When was your last spinal X-rays taken? _____

Did your family receive chiropractic care?

☐ Yes ☐ No ☐ N/A

Who can we thank for this referral?

☐ Patient from this office (name)

_____

☐ Other Health Care Professional (name)

_____

☐ Walk By/Sign

☐ Website

☐ Yellow Pages.ca

☐ Google

☐ Other internet search engine

☐ Other (specify) _____

What is the purpose of this appointment? Describe in detail: _____

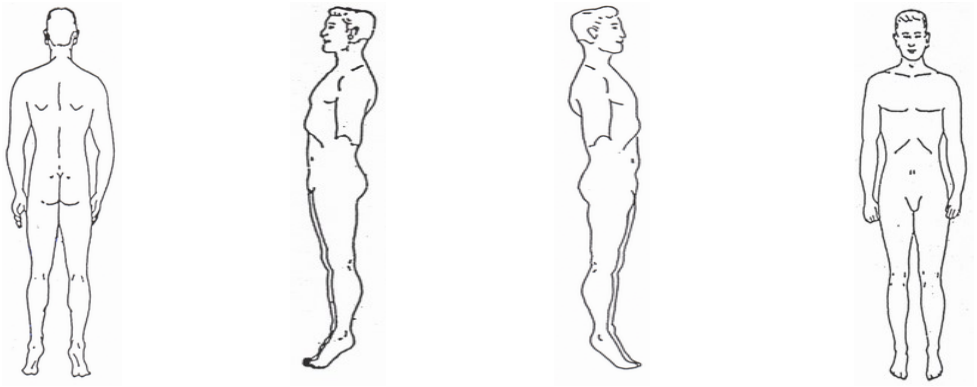
_____

_____

_____

*Patient Name:*_____

Please indicate (circle) on the diagram below the area (s) in which you are experiencing problems.



Is the purpose of this appointment related to

☐ Work ☐Stress ☐ Sports ☐ Auto ☐ Fall ☐ Chronic Discomfort ☐ Repetitive Trauma ☐ Check-Up ☐ Other

Please explain _____

_____

How long have you had this condition? _____ Have you had this or similar conditions in the past? (When?)_____

What activities aggravate your condition? _____

Is there anything that relieves the symptoms? _____

Has this condition: ☐ gotten worse ☐ stayed constant ☐ comes and goes ☐ improving

Does this condition interfere with ☐ work ☐ sleep ☐ daily routine ☐ childcare responsibilities ☐ sports ☐ other activities (explain)

_____

_____

On a scale of 0 to 10 (with 0 being no pain, and 10 being the worst pain, rate your concerns by **circling the number**.

0 1 2 3 4 5 6 7 8 9 10

Have you ever had an X-ray, CT Scan, MRI, Bone Scan? ☐ Yes ☐ No (If yes, Where?) _____ (When?) _____

What were the results? _____

_____

Have you seen any other care providers for this condition? ☐ Yes ☐ No (If yes, explain)_____

_____

Practitioner's Name _____ Type of Care _____

Date _____ Results _____

Injuries:

Have you ever broken a bone (s)? ☐ Yes ☐ No _____

_____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐ Yes ☐ No

_____

_____

Sprains, strains, dislocations (give details and how long ago): _____

_____

Surgical operations (give details and how long ago): _____

_____

Have you ever been hospitalized for any other reason? ☐ Yes ☐ No (give details): _____

_____

_____

*Patient Name:*_____

My Health Conditions

Please circle either **C for Current or P for Past** diseases or conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, care plan, and the possibility of being accepted for care or referred to another practitioner, if necessary.

General

C P - Allergy
C P - Convulsions
C P - Dizziness/Vertigo
C P - Fatigue
C P - Headache
C P - Migraines
C P - Loss of sleep
C P - Loss of weight
C P - Cancer:_____
_____
C P - Numbness
C P - Anxiety
C P - Depression
C P - Diabetes
C P - Thyroid problems
C P - Epilepsy
C P - Hyperactivity
C P - Gout
C P - Polio
C P - Poor posture
C P - Swollen Joints
C P - Fractures:_____
_____

Numbness or pain in:

C P - Shoulder
C P - Upper Arms
C P - Hands
C P - Legs
C P - Feet

Gastro-Intestinal

C P - Liver trouble
C P - Constipation
C P - Diarrhea
C P - Digestive dysfunction
C P - Gall bladder trouble
C P - Hemorrhoids
C P - Ulcers

Cardio-Vascular

C P - High blood pressure
C P - Low blood pressure
C P - Poor circulation
C P - Irregular heart beat
C P - Anemia
C P - Arteriosclerosis
C P - Stroke
C P - Ankle swelling

Eyes, Ears, Nose and Throat

C P - Asthma
C P - Frequent colds
C P - Crossed eyes
C P - Deafness
C P - Ear infections
C P - Ringing in the ears
C P - Eye pain
C P - Vision problems
C P - Nasal obstruction
C P - Sinus Problems
C P - Jaw Problems

Muscle and Joint

C P - Arthritis
C P - Hernia
C P - Low back pain
C P - Neck pain
C P - Pain between shoulder blades
C P - Rib Pain Left / Right
C P - Disc Herniation
C P - Sciatic
C P - Knee Pain
C P - Ankle Pain
C P - Other (not listed):_____

Respiratory

C P - Chest pain
C P - Chronic cough
C P - Irregular breathing
C P - Wheezing
C P - Emphysema

Genito– Urinary

C P - Bed-wetting
C P - Painful urination
C P - Prostate trouble
C P - Blood in urine

Women Only

C P - Menstrual cramps
C P - Excessive menstruation
C P - Irregular cycle
C P - Hot flashes

Are you pregnant? ☐ Yes ☐ No

If Yes: Expected due Date:

_____

SOURCES OF SPINAL STRESSES

To help us determine the cause of your problem, please indicate, on this page and the next, potential sources of spinal trauma.

General Physical Trauma

(Details and Dates)

☐ As infant or child _____
☐ Down stairs _____
☐ On ice _____
☐ Sports impact _____
☐ Physical fight _____
☐ Other _____

Primary Daily Activities

☐ sitting ☐ standing ☐ walking ☐ desk work ☐ telephone
☐ driving ☐ manual repetitive work ☐ heavy lifting

Exercise

☐ heavy/daily ☐ moderate/recreational ☐ Periodic

Describe_____

Auto Accidents

Have you ever, even as a passenger, even if you did not think you were hurt, been involved in a car accident? ☐ Yes ☐ No

If yes, please indicate approximate dates and severity below :

_____

If your chief complaint is in direct response to a motor vehicle accident, please notify our staff, as we will require a separate questionnaire to document your accident and injury.

*Patient Name:*_____

History of Chemical Stress

Medication I am presently taking

☐ Pain Killers _____

☐ Anti-inflammitories _____

☐ Muscle Relaxants _____

☐ Blood Pressure Medications _____

☐ Stimulants _____

☐ Anti-depressants _____

☐ Tranquillizers, Anti-anxiety _____

☐ Blood Thinners _____

☐ Birth Control Pills _____

☐ Other _____

_____

Health Habits

	Heavy	Moderate	Light	None
Tobacco	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐

	Good	Fair	Poor	None
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Personal Stress Levels

	Good	Fair	Poor
Past	☐	☐	☐
Present	☐	☐	☐

Fee Schedule:

Initial Consultation Fee: $67.00

Subsequent Visit Fee: $52.00

X-ray Fee: $37.50 per view

Nervous System Scan: $75.00

FOB or ID Card: $5.00 (Refundable with un-damaged devices)

I, the undersigned, understand that services rendered in this office are responsibility of myself should Medical Services Plan or other third party plans fail to pay all or part of the amount due. I understand 24 hours notice is requested for cancellation of an appointment. I, the undersigned, also understand that each Practitioner is an independent and separate practice operating under Impulse Health And Wellness. I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary. In the event that X-rays are necessary in my case, I understand and agree that X-rays taken in this clinic are the property of Impulse Chiropractic & Massage Therapy, and will remain in this clinic where they can be reviewed for me by the Doctors. I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable.

Patient's Signature_____ **Date** _____

(or signature of guardian or spouse authorizing care)

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 exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of neck, back, and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headaches, 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 and 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 infrequent, 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)

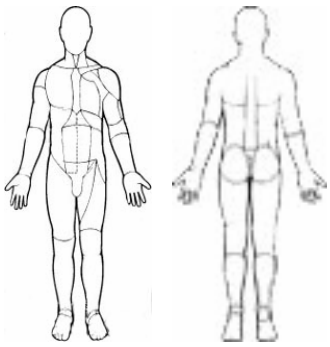
_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

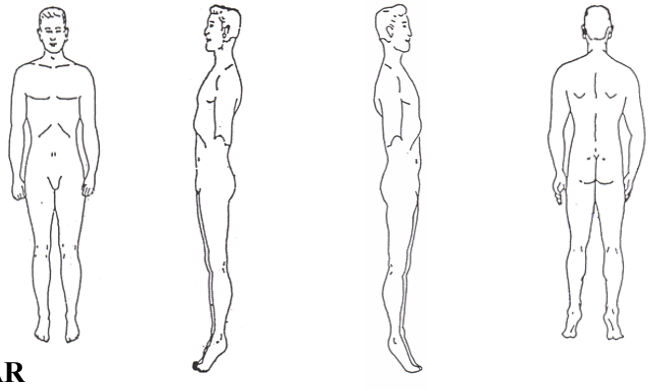
PATIENT NAME: **Impulse Chiropractic Clinic** **FILE#:**

DATE: **EXAMINATION FORM**

MYOFASCIAL FINDINGS

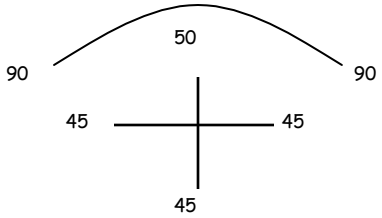


POSTURAL

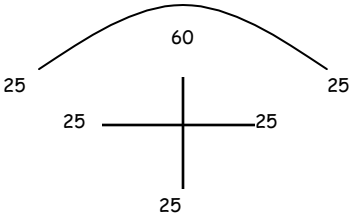


ROM

CERVICAL



LUMBAR



VITALS B.P.: Pulse:
Height: Weight:

REFLEX

L	R
Biceps(C5)	
Brachialis(C6)	
Triceps(C7)	

MOTOR

L	R
Sh. Abd.(C5)	
Elbow Flex(C6)	
Elbow Ext(C7)	
Wrist Ext(C6)	
Wrist Ext(C7)	
Grip(C8)	
Finger Abd.(T1)	

SENSORY

L	R
C5	
C6	
C73	
C8	
T1	

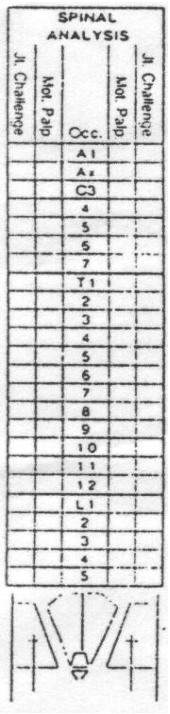
CRANIAL NERVES

1Olfactory	7Facial
2Optic	8VestibCoch
Oculomotor	9Glosspharygl
4Trochlear	10Vagus
5Trigeminal	11Sp. Access.
6Abducens	12Hypoglossal

Patella(L4)	Knee Ext(L3)	L2-3
Med. Ham(L5)	Knee Flex(S1)	L4
Achilles(S1)	Dorsiflexion(L4)	L5
	Plantarflex/Eversion(S1)	S1
	1st MTP Ext(L5)	

CHIRO PALPATION

L R



ORTHOPEDIC EXAM

C/S

L	R
Spinous Percussion	
Kemps	
Jacksons	
Compression	
Distraction	
Doorbells	
Adson	
Costoclavicular	
Wright's	
Shoulder Depression	
Facet Rub	
Digital Pressure	
VBI Test	

L/S

L	R
Spinous Percussion	
Kemps	
SLR	
Braggards	
Bowstrings	
PatrickFabere	
Mod. Thomas	
Gaenslens	
Yeoman	
Erichsons	
Sciatic NotchTTT	
Ely's	
Hibbs	
Facet Rub	
Digital Pressure	

T/S

Chest Expasion(AbN<3cm)
Scapular Approx. T1,T2 n.
Sternal Compression

Valsalva
Babinski Clonus
Brudzinski Kernig's
Soto Hall
L'Hermitte's
Schober's Test(AbN<3cm)
Waddell's:
-AxialLoad/Trk Rotn
-Exaggeration/OverRxn
-AbN Rxn to Neurology
-Light Pinch/Deep Press
-Distraction SLR

PATIENT NAME: **FILE #:**

DATE:

PATIENT HISTORY FORM

C.C.

LOCATION

ONSET
- -traumatic
- -insidious
- -mechanism

FREQUENCY
- -const./intermit.

PROGRESSION

DURATION

CHARACTER
- -dull/sharp
- -burning/gnawing

INTENSITY 0-10

RADIATION

AGGRAVATING
- -flex./ext./lat.flex./rotn.
- -cough/sneeze/straining
- -lying/sitting/standing/walking

RELIEVING
- -ice/heat
- -rest/movement/exercise

MEDICATION

PREVIOUS Tx
- -DC
- -MD/Rx
- -Physio
- -Massage

PREVIOUS OCCURANCE

ASSOC Sx

SYSTEMS REVIEW
- -lungs/heart/GI/GU/HA...

PAST ILLNESS
- -hospital/surgery/allergy

PREVIOUS MVA

PREVIOUS X-RAYS

FAMILY HISTORY
- -diabetes/heart/CA/arthritis