Information reviewed with patient:
*Dr. Initials*____________

*Today's Date*_________________

Brisbin Family Chiropractic

Name:____ Sex: Male ___ Female ___
Address:____
City:__________________________________ Postal Code**:** _____________
Home Ph# __________________ Work# _____________________ Ext#_________ Cell# ______________________
Preferred number (circle one) Home Work Cell
Date of Birth: ______________________________Age: __________
Email:____ □ I do not want to be contacted via email
Occupation:______________________________________ Employer:_______________________________________
Spouse's Name: ___________________________________
Names of Children and Ages: ____
Alberta Health Care#: ____
Emergency Contact:________________________Phone:______________________Relationship:_________________

Have you ever received Chiropractic care? Yes ___ No ___
If yes, who: ______________________________________When: ____

How did you find out about our office?____
If you were referred to our office, who may we thank? ____

Have you received **spinal x-rays** in the last 2 years? Yes ___ No ___
Do you wear orthotics or special shoe inserts? Y/N (if yes, how old are they?) _____________________________
Is this related to a Motor Vehicle Accident in the **last 10 days**? Yes ___________ No __________
If yes, Date: _______________________________
Is this a work related injury (**WCB Claim**)? Yes ___No ____
Is there a chance you could be **pregnant**? Yes ___No ____

Existing Symptoms

If you have a specific chief complaint(s), please describe briefly: (Include how and when problem started)
____
____
____

CIRCLE ALL THAT APPLY

The problem occurred: Gradually Suddenly
Condition is worse with: Right rotation Left rotation / Forward bending / Backward bending / Right bending / Left bending
Is the problem: Constant Intermittent
Is it worse in the: AM PM Same through day
Does it radiate? Yes No If yes, where?___________________
Is the pain getting progressively worse? Yes No
The condition interferes with my: Sleep / Work / Daily routine / Family life / Exercise / Mood

What activities aggravate your condition/pain?
____

What (if anything) relieves your condition/pain?
____

Pain Diagram

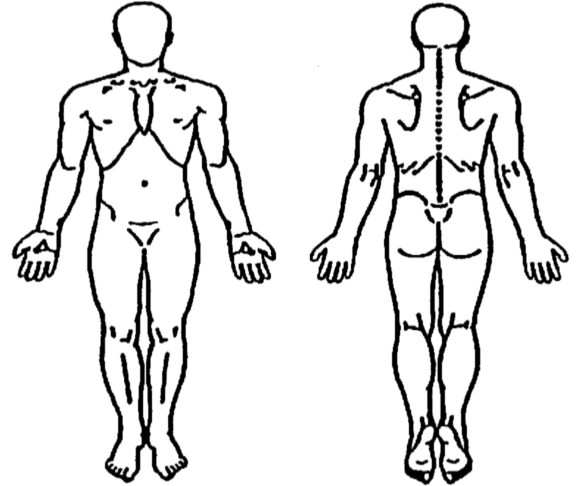
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.

Numbness (XX), Pins & Needles (+ +),

Aching (**), Burning (- -), Stabbing (/ /)

On a scale between 1 (no pain) and 10 (intense pain), place an X where you are currently at:

1----2----3----4----5----6----7----8----9----10



System review

Please indicate by circling any of the following conditions you may be experiencing or have experienced in the past

Headaches	Migraines	Neck pain
Chronic fatigue	Ringing in the ears	Dizziness
Ear infections	Sinus problems	Swallowing difficulties
Vision changes	Sleeping problems	Wrist pain
Carpal tunnel	Arm pain	Depression
Shoulder pain	Upper back pain	Chronic nausea
Mid back pain	Heartburn	Asthma
Chest pain	Leg pain	Constipation
Low back pain	Diabetes	Diarrhea
Blood pressure	Cancer	Foot pain
Bladder control	Sexual dysfunction	Allergies
Sciatic pain	Osteoporosis	Cramping in legs
Arthritis	Scoliosis	Degenerative disc

Is there a family history of (circle)

Heart disease / Stroke / Cancer / Diabetes / Other

Please list any medications or vitamins that you are currently on: ____

____

List any surgeries you have had and include when: ____

____

Lifestyle Events and Habits

The 3 main stressors that may compromise your well-being:

Physical Stress

Briefly describe any notable **injuries, head traumas, concussions, broken bones, slips or falls**

____

____

List any **Motor Vehicle Accident** injuries: include date if known and describe collision (rear-end, roll-over, etc)

____

____

Circle what you spend most of your day doing:

Sitting / Bending forward / Twisting / Lifting / Driving / Computer

If yes to sitting/driving/computer, how many hours per day do you spend at these activities? ________

Do you exercise on a regular basis? Yes No

Do you sleep on your: Back / Side / Stomach

Rate your posture out of 10 (1 – poor 10 – excellent):

1----------3----------5----------8----------10

Rate the amount of physical stress that your body goes through on a daily basis:
(1 – no physical stress 5 – moderate physical stress 10 – heavy stress load):

1----------3----------5----------8----------10

Chemical Stress

Do you smoke? Yes No If so, how much and how long? ____________________________

Alcohol consumption: Yes No If yes, how much? Rarely Weekly Daily

My caffeine intake is: Low Moderate High

I eat processed foods: Rarely Occasionally Often

I use over the counter drugs (Aspirin, etc): Rarely Occasionally Often

Emotional Stress

My stresses include: Work Home School Finances Family
Relationships Health Other? ______________________________

Rate your stress level (1 – rarely stressed 10 – always stressed)

1----------3----------5----------8----------10

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 the 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 with only last 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 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