OFFICE USE ONLY

Diagnostic Code _____
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: _____
Have you ever received Chiropractic care? Yes ___ No ___
If yes, who: _____ When: _____
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?) _____
Alberta Health Care#: _____
How did you find out about our office?_____
If you were referred to our office, who may we thank? _____
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)

_____
_____
_____

* **MARK ALL THAT APPLY***

Is the problem: Constant? _____ Intermittent? ____ Worse with movement? _____
Is the condition worse: In the AM? ___ In the PM? ___ No change? ___
The problem occurred: Gradually? ____ Suddenly? ____
Does it radiate? Yes_____ No_____ If yes, where?_____
Is the pain getting progressively worse? Yes? ___ No? ___
Condition is worse with: Right rotation? ___ Left rotation? ___
Bending: Forward? ___ Backward? ___ Right? ___ Left? ___
The condition interferes with my: Sleep? ___ Work? ___
Daily Routine? ___ Family Life? ___ Exercise? ____ Mood?_____

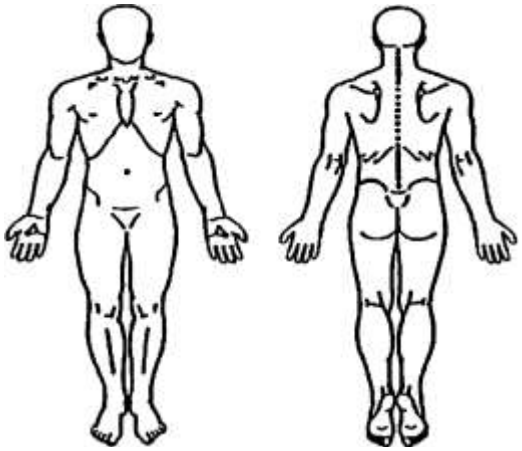
What activities aggravate your condition/pain?
_____

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

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

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

Show area(s) of pain or unusual feeling. Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.



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

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

System Review

Please select anything you suffer from or have a history of suffering from below by marking "C" for current or "P" for previous, and provide a brief description

___Headaches		___Migraines	
___Neck Pain		___Ringing in ears	
___Chronic Fatigue		___Upper Back Pain	
___Low Back Pain		___Shoulder Pain	
___Arm Pain		___Wrist Pain	
___Carpal Tunnel		___Constipation	
___Diarrhea		___Leg Pain	
___Foot Pain		___Depression	
___Sleeping Problems		___Dizziness	
___Allergies		___Cramping in Legs	
___Heartburn		___Vision changes	
___Chest pain		___Blood pressure	
___Bladder Control		___Ear Infections	
___Sinus		___Sciatic Pain	
___Arthritis		___Swallowing Difficulty	
___Asthma		___Diabetes	
___Cancer		___Sexual Dysfunction	
___Osteoporosis		___Scoliosis	
___Degenerative Disc Disease		Other:_____ _____	

Is there a family history of:

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:

1. Physical Stress

Briefly describe any notable **injuries, head traumas, concussions, broken bones, slips or falls** (example: sports, horseback riding, tobogganing, falls down stairs, slips on ice). Remember to include how old you were at the time, as childhood injuries left uncorrected can lead to problems later in life.

_____

_____

List any **motor vehicle accident** injuries: include date if known and describe collision (rear-end, roll-over, seatbelt, airbags?)

_____

_____

Do you spend any significant time:

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

2. Chemical Stress

Do you smoke, if so, how much and how long? _____

Drink alcohol? Daily? ___ Week-ends? ___ Socially? ___

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? ___

3. Emotional Stress

My stresses include: Work? ___ Home? ___ School? ___ Finances? ___ Family? ___

Relationships? ___ Health problems? ___ Other? _____

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

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

OFFICE USE ONLY

BWD L _____ R _____

FTN: + -

BALANCE TEST: + - (R / L)

MITTLEMEYERS: + - (FORWARD / R / L)

ROM: C-Spine:

rot R	(N ⩛) (with pain/without pain)	_____
rot L	(N ⩛) (with pain/without pain)	_____
lat R	(N ⩛) (with pain/without pain)	_____
lat L	(N ⩛) (with pain/without pain)	_____
Flex	(N ⩛) (with pain/without pain)	_____
Ext	(N ⩛) (with pain/without pain)	_____

T-L Spine:

rot R	(N ⩛) (with pain/without pain)	_____
rot L	(N ⩛) (with pain/without pain)	_____
lat R	(N ⩛) (with pain/without pain)	_____
lat L	(N ⩛) (with pain/without pain)	_____
Flex	(N ⩛) (with pain/without pain)	_____
Ext	(N ⩛) (with pain/without pain)	_____

Dr. use only

Carotid artery auscultation Bruits Yes / No

N=normal / ⩛= decreased

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