LIVE WELL
FAMILY CHIROPRACTIC

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Edmonton, AB T5R 4G5
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Confidential Health History

Name		Birthdate:	/ / (Age:)
Address			DD/MM/YYYY
City	Edmonton Other:	Sex:	Female Male
Postal Code		Occupation:	
Mobile No.	( ) -	Employer:	
Home No.	( ) -	Alberta Health Number:	
Email			

Are you currently a **student**? Yes___ No___

Is there a chance you could be **pregnant**? Yes___ No___

Is this related to a car accident in the **past 10 days**? Yes___ No___

Is this related to a workplace injury (**WCB Claim**) Yes___ No___

Who can we thank for referring you to our office? _____

How do you know them?_____

If you were not referred by a friend or family, how did you hear about our office?_____

Have you been to a Chiropractor before? Yes No

If Yes, Who _____ When was your last visit? _____

Do you wear orthotics or special shoe inserts? Yes No If yes, how old are they? _____

Emergency Contact:_____ Phone Number:_____

Why This Form is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better asses the challenges to your present and future health.

Specific Concern History

Reason for today's visit: Wellness Check-Up or Specific Concern

Please describe your primary concern:_____

_____

When did this problem begin?_____

How frequent is this problem? Constant Daily Weekly Other:_____

How has it progressed recently? Same Improving Getting Worse

Describe the pain: Sharp Dull Numbness Tingling Aching Burning

Stabbing Throbbing Other:_____

Does the pain radiate into: chest arms hands hips legs feet none

On a scale of 1 (no pain) to 10 (severe pain) rate your pain: ____on average ____at best ____at worst

What aggravates this problem?_____

Have you ever experienced a similar problem in the past? No Yes, When:_____

Does this condition disturb your:	**What have you tried to relieve the pain?**	**Check all the TRUE statements:**
___ Career	_____ Prescription Drugs/ Pain Relievers	_____ Previous help has been ineffective.
___ Family Life	_____ Physical Therapy	_____ My problem could get worse.
___ Ability to Exercise	_____ Exercise / Stretching	_____ I want to be more energetic.
___ Sleeping Pattern	_____ Massage	_____ I want answers and results.
___ Quality of Life	_____ Nothing	_____ I want better health.

What else does your problem prevent you from doing or enjoying?_____

How long has it been since you really felt well?_____

Rate the importance of finding the **CAUSE** of your problem: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Rate the importance of your Quality of Life: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

My biggest obstacles to getting well will be: Time Money Other:_____

As a result of my Chiropractic care, I would like to: (Please circle all that apply)

Feel better quickly Long lasting Results Correct the Problem Prevent Permanent Damage

Systems Review

Please check any symptoms that are currently affecting your quality of life, even if you do not believe them to be Chiropractic related.

___ Headaches/Migraines	___ Difficulty Swallowing	___ Lower Back Pain	___ Fatigue
___ Carpal Tunnel	___Shortness of Breath	___ Constipation	___ Sleeping Problems
___ Dizziness/Vertigo	___ Upper Back Pain	___ Diarrhea	___ Frequent Colds/Flus
___ High Blood Pressure	___ Asthma	___ Bloating/Gas	___ Arthritis/Degeneration
___ Vision Changes	___ Cough	___ Sciatic Pain	___Cancer
___ Allergy/Sinus Problems	___ Chest Pain	___ Cramping in legs	___ Osteoporosis
___ Seizures	___Heartburn	___ Leg Pain	___ Scoliosis
___Ear Infections	___Diabetes	___ Foot Pain/Numbness	___ Depression
___ Arm/Shoulder Pain		___Bladder Control	
___ ADD/ADHD		___ Sexual Dysfunction	
___ Neck Pain		___ Bedwetting	

WOMEN ONLY			
___ Painful Menstration	___Irregular Cycles	___ Hot Flashes	___ Infertility
___ Miscarriage	___ PMS	___ Endometriosis	___ Early Onset Menopause
	_____ # of pregnancies	_____ # of births	
Have your ever experienced with birth?	_____ C-Section _____ Forceps	___ Epidural ___ Vacuum Suction	___ Induction ___ Breech Baby

Surgeries:

Date:	Type and Reason for Surgery
_____	_____
_____	_____

Medications — Reason for Taking:

_____ _____
_____ _____
_____ _____

Supplements — Reason for Taking:

_____ _____
_____ _____
_____ _____

Is there a family history of: (circle all that apply)

Heart disease Stroke Cancer Diabetes Thyroid Problems Other:_____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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 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 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 also 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.

_____ Date: _____ 20____.
Name (Please Print)

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

_____ Date: _____20____
Signature of Chiropractor