WESTWOOD FAMILY CHIROPRACTIC

Today's Date: _____

MHSC REGISTRATION # (6 DIGIT) _____ **(9 DIGIT)** _____
First Name: _____ Last Name: _____
I am a Male/Female (circle) Birthday (d/m/y): _____/_____/_____ Current Age: _____
Street Address: _____
City: _____ Province: _____ Postal Code: _____
Home #: _____ Work #: _____ Cell #: _____
Email Address: _____
Occupation: _____ Employer: _____
Spouse's Name: _____ # of Children: ____ Ages of children: _____
How did you hear about us? _____
Emergency Contact Name and #: _____

Will you be claiming: Autopac (MPI): Y/N Worker's Compensation: Y/N
If yes: Injury/Accident Date: _____ Personal Injury Claim #: _____

CHIROPRACTIC HISTORY:
Have you been to a chiropractor before? Y/N Date of last visit: _____
Name of last chiropractor: _____ Did they take X-rays? Y/N

What are your health goals?

☐ Symptom relief and preventing its return
☐ 100% optimum health and wellbeing on every level available to me

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MAJOR HEALTH CONCERN #1 – PLEASE FILL IN ALL AREAS: IF NOT APPLICABLE PUT "N/A"

What condition brought you to our office? _____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/10
When did it start? _____ How? _____
Is it…
☐ Getting better ☐ Getting worse ☐ Staying the same
How many times a week do you feel the pain? _____
What percentage of the day do you feel pain? 25% 50% 75% 100%
How would you describe the problem? _____
Are you taking medication for this condition? Y/N (circle)
If yes, which medication? _____ Dose: _____
Do you have family history of this same condition? Y/N (circle)
Have you seen anyone else for this condition? Y/N (circle) Who? _____
Any significant family medical conditions/history? Y/N_____
Describe the physical nature of your occupation_____
Do you smoke? Y/N (circle)
Do you consume alcoholic beverages? Y/N (circle) If yes, how many/week? _____
Please list ANY medications you are currently taking: _____
_____

Have you ever been in a car accident? Y/N (circle) If yes, when? _____

YOUR HEALTH HISTORY:

Please check all that you have experienced in the last six months to present:

☐Headaches	☐Migraines	☐Dizziness	☐Sinus Problems
☐Depression	☐Neck Pain	☐Shoulder Pain	☐Ringing in Ears
☐Ear infections	☐Allergies	☐Upper Back Pain	☐Hand/Wrist Pain
☐Gout	☐Chest Pain	☐Fatigue	☐Mid back Pain
☐Rib Pain	☐Jaw Problems	☐Heart Disease	☐Low Back Pain
☐Ankle/Knee Pain	☐Heartburn	☐Diarrhea	☐Hip Pain
☐Cancer	☐Constipation	☐Diabetes	☐Menstrual Cramps
☐High Blood Pressure	☐Difficulty Breathing	☐Stomach Pain	☐Asthma
☐High Cholesterol	☐Difficulty Sleeping	☐Anxiety	☐Decreased Energy
☐Arthritis	☐Thyroid Condition	☐Stroke	☐Jaundice
☐Carpal Tunnel Syndrome	☐Hot Flashes	☐Ulcers	☐Other

Please fill out the following information on the *above* most serious conditions; or any other condition that you may have (excluding "Major Health Concern" on page 1):

Condition 1: _____
On a scale of 1-10 (10 being severe), how bad is the problem? _____/10
When did it start? _____ How? _____
It is
☐ Getting better ☐ Getting worse ☐ Staying the same
How many times a week do you feel the pain?_____
What percentage of the day do you feel pain? 25% 50% 75% 100%
How would you describe the problem? _____
Are you taking medication for this condition? Y/N
If yes, which medication? _____ Dose: _____

Condition 2: _____
On a scale of 1-10 (10 being severe), how bad is the problem? _____/10
When did it start? _____ How? _____
Is it:
☐ Getting better ☐ Getting worse ☐ Staying the same
How many times a week do you feel the pain?_____
What percentage of the day do you feel pain? 25% 50% 75% 100%
How would you describe the problem? _____
Are you taking medication for this condition? Y/N
If yes, which medication? _____ Dose: _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and that Westwood Family Chiropractic has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____ _____
Signature Date

Consent to Chiropractic Treatment Standard of Practice S-05

It's 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 joint 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 spasms. It can also increase mobility, improve functions and reduce or eliminate the need for drugs or surgery.

Risks
The risks associated with chiropractic treatment may 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 affected area 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 neck movements have been associated with a 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.

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 YOUR CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks or treatment, as well as the alternative to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____

Name (Please Print)

_____ _____

Signature of Patient (or Legal Guardian) Date

_____ _____

Signature of Chiropractor Date