NEW PATIENT HISTORY FORM **Date:** _____

At Parascak Family Chiropractic we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you into this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, emotional, and chemical stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced throughout your lifetime, allowing us to better assess the challenges to your health potential.

Referred To This Office By: _____
Last Name: _____ First Name: _____ Initial: _____
Address: _____Postal Code_____
Home Phone: _____Bus. Phone: _____Ext.: _____Cell:_____
Email Address: _____
Occupation: _____Work Place: _____
Extended Health Care Insurance: Yes □ No □ Alberta Health Care #: _____
Date Of Birth (D/M/Y): _____ Age: _____ Sex: M □ F □
Marital Status: S □ M □ D □ W □ Spouse's Name: _____
# of Children: _____ Children's name and ages: _____

THE BEGINNING YEARS (to age 17)

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood History

□ Born by Vacuum
□ Born by Forceps
□ Born by Caesarean
□ Born Breech
□ Stomach sleeper as a child
□ On Antibiotics as a child
□ Used puffers as a child
□ Vaccinations as a child

Childhood illnesses: _____
_____
Childhood surgeries: _____
_____
Childhood injuries, falls, car accidents: _____
_____
Contact Sports: _____
_____

ADULT YEARS (Age 18 to present)

After Childhood to Present

□ Smoke
□ Drink Alcohol
□ Eat unhealthy foods
□ Little to no exercise
□ Occupational stress
□ Home Stress
□ Physical Stress
□ Computer (home or work)
□ Sit at work mostly
□ Stand at work mostly
□ Stomach sleeper

Surgeries_____
_____
#of Medications/day_____
What do you take medications for?
1)_____2)_____
3)_____4)_____
Sports/Hobbies_____
_____
Car Accidents: When_____
Briefly describe_____
Falls/Injuries _____When_____
_____When_____

CURRENT LIFESTYLE

Your current lifestyle determines how healthy you are now and how well your body will heal. Please rate your current health on a scale of 0 – 10 (optimal).

diet _____ exercise _____ sleep _____ emotional/spiritual _____

Many times symptoms indicate a long-standing spinal condition. Please check off any symptoms you have now or have experienced in the past.

Past	Present		Past	Present	
□	□	Headaches	□	□	Difficulty Breathing/sinuses
□	□	Fatigue	□	□	Asthma
□	□	Irritability	□	□	Frequent colds/flues
□	□	Depression	□	□	Ulcers
□	□	Neck Pain	□	□	Digestive problems
□	□	Dizziness	□	□	Low Back/Hip Pain
□	□	Loss of Concentration	□	□	Constipation
□	□	Difficulty Sleeping	□	□	Diarrhea
□	□	Mid Back Pain	□	□	Menstrual pain
□	□	Arm/hand pain or numbness	□	□	Leg/foot pain or numbness
□	□	Chest pain	□	□	Cancer
□	□	Heart Problems	□	□	Diabetes
□	□	Heartburn	□	□	Stroke
□	□	Skin problems	□	□	Bladder/urinary tract problems

Please describe the location of your symptoms or reasons for making this appointment: _____
_____
_____
How long have you had this condition? _____ Have you had a similar condition in the past? _____
What makes it worse? _____
What relieves it? _____
Do you feel your symptoms have been getting: □ better □ same □ worse?
Is the pain: □ sharp □ dull □ burning □ tight □ throbbing □ numb?
Is this condition interfering with your: □ work □ home routine □ family?
What doctors have you seen about this condition? _____
Have you seen a Chiropractor before? □ yes □ no When?_____
Approximately how many visits? _____

Family History

	Heart Disease	Arthritis	Cancer	Diabetes	Other: _____
Father's side	□	□	□	□	
Mother's side	□	□	□	□	

For women: Are you pregnant? □ Yes □ No □ Trying □ Unsure Date of last menstrual period: _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief while others are interested in having the cause of the problem corrected.

Please check the type of care you desire:

□ *RELIEF CARE* – is aimed at eliminating your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

□ *CORRECTIVE CARE* – differs from relief care in that its goal is to get rid of symptoms or pain while correcting the cause of the problem. Corrective care varies in its length of time, but is more lasting.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short-term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Print Name: _____ Signature: _____

Date signed: _____ Witnessed by (staff): _____