Lifeforce Proactive
HEALTH CENTRE

Date: ____________________ Case #: ____________

First Name: _______________ Last Name: ___________________

Birth Date: M ____ D ____Y ____ __ Age _____ Care Card # :____________________________

Address: ________________________________ City: _______________________________

Province: ________ Postal Code: ___________ Best Contact Number: ________________________

Home Phone: ________________Work Phone: ________________ Cell Phone: ________________

Type of Work: _______________ Extended Insurance? ■Yes ■ No

**Email Address for Appointment Reminders**: ____________________________

If you like to receive our monthly newsletter with office updates and valuable health tips please sign below

___________________

## HEALTH HISTORY

**Is this visit a result of a Motor Vehicle Accident or Work Safe BC Injury? ■ Yes ■ No**

**If yes, please advise the receptionist for appropriate ICBC or WCB form.**

- Family Dr.: ____________________Location:_________________
- May we communicate health concerns with your Medical Doctor? ■ Yes ■ No
- Purpose of this Appointment? ______________________________________
- What is your primary complaint? ____________________________________
- When did this condition begin? _____________________________________
- Is your condition getting better, worse or staying the same? ______________
- What aggravates your condition? ___________________________________
- What relieves your condition? ______________________________________
- Are there others in your family with this same condition? ■ Yes ■ No
- Have you seen any other health practitioner's for this condition? ■ Yes ■ No

  If yes, Who?_________________________________________________
- Medication you are taking now ■ Nerve pills ■ Pain Killers/Muscle Relaxers ■ Blood Pressure ■ Insulin

  ■ Aspirin/Similar ■ Other ______________________________________________

  If yes, for what condition? ________________________________________________
- Major Illnesses / Surgery / Operations? ______________________________________
- Major accidents or Falls ________________________________________________
- Hospitalization (other than above) __________________________________________
- Family history of illness or Disease __________________________________________

  ________________________________________________________________________
- Have you ever had X-rays before? ■ Yes ■ No
- If yes, when and why? _________________________________________________

**Please Circle Referral Source**

**Patient**

**________________**

**Practitioner**

**________________**

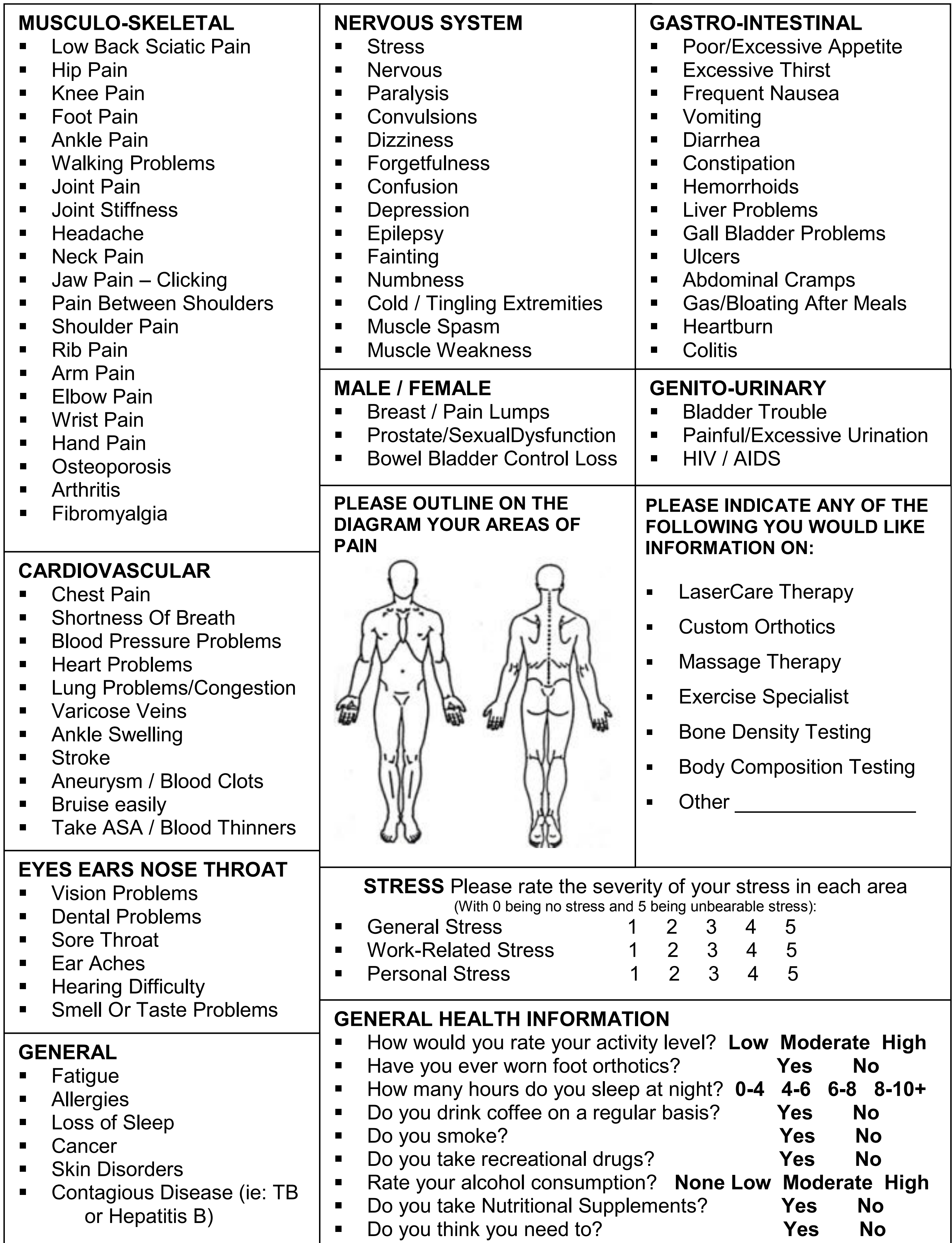
**Yellow Pages**
**Live in Area**
**Website**
**Facebook**
**Health Talk**
**Google**
**Yahoo**
**Bing**

**Females only**

- When was your last period __________ Are you pregnant? ■ Yes ■ No If Yes, Due date ___________
- Did you have severe back pain during or after your pregnancy? ■ Yes ■ No # of Children ___________
- Do you experience menstrual irregularity or cramping? ■ Yes ■ No
- Are you Menopausal ■ Yes ■ No Date of Last Bone Density Assessment_______________

Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these symptoms can affect your overall course of care.

**CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE HAD IN THE PAST 6 MONTHS**



### MUSCULO-SKELETAL
- Low Back Sciatic Pain
- Hip Pain
- Knee Pain
- Foot Pain
- Ankle Pain
- Walking Problems
- Joint Pain
- Joint Stiffness
- Headache
- Neck Pain
- Jaw Pain – Clicking
- Pain Between Shoulders
- Shoulder Pain
- Rib Pain
- Arm Pain
- Elbow Pain
- Wrist Pain
- Hand Pain
- Osteoporosis
- Arthritis
- Fibromyalgia

### CARDIOVASCULAR
- Chest Pain
- Shortness Of Breath
- Blood Pressure Problems
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke
- Aneurysm / Blood Clots
- Bruise easily
- Take ASA / Blood Thinners

### EYES EARS NOSE THROAT
- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Smell Or Taste Problems

### GENERAL
- Fatigue
- Allergies
- Loss of Sleep
- Cancer
- Skin Disorders
- Contagious Disease (ie: TB or Hepatitis B)

### NERVOUS SYSTEM
- Stress
- Nervous
- Paralysis
- Convulsions
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Epilepsy
- Fainting
- Numbness
- Cold / Tingling Extremities
- Muscle Spasm
- Muscle Weakness

### GASTRO-INTESTINAL
- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Ulcers
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Colitis

### MALE / FEMALE
- Breast / Pain Lumps
- Prostate/SexualDysfunction
- Bowel Bladder Control Loss

### GENITO-URINARY
- Bladder Trouble
- Painful/Excessive Urination
- HIV / AIDS

**PLEASE OUTLINE ON THE DIAGRAM YOUR AREAS OF PAIN**

**PLEASE INDICATE ANY OF THE FOLLOWING YOU WOULD LIKE INFORMATION ON:**

- LaserCare Therapy
- Custom Orthotics
- Massage Therapy
- Exercise Specialist
- Bone Density Testing
- Body Composition Testing
- Other _________________

**STRESS** Please rate the severity of your stress in each area
(With 0 being no stress and 5 being unbearable stress):

| | | | | | |
|---|---|---|---|---|---|
| General Stress | 1 | 2 | 3 | 4 | 5 |
| Work-Related Stress | 1 | 2 | 3 | 4 | 5 |
| Personal Stress | 1 | 2 | 3 | 4 | 5 |

### GENERAL HEALTH INFORMATION
- How would you rate your activity level? **Low Moderate High**
- Have you ever worn foot orthotics? **Yes No**
- How many hours do you sleep at night? **0-4 4-6 6-8 8-10+**
- Do you drink coffee on a regular basis? **Yes No**
- Do you smoke? **Yes No**
- Do you take recreational drugs? **Yes No**
- Rate your alcohol consumption? **None Low Moderate High**
- Do you take Nutritional Supplements? **Yes No**
- Do you think you need to? **Yes No**

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## Patient Stress Assessment

**Patient Name:** ____________________ **Date:** ______________ **Case #:** ____________

**1.** **Please rate your pain** by **circling** the one number that best describes **your pain** at its **WORST** in the past week.

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

**2.** **Please rate your pain** by **circling** the one number that best describes **your pain** at its **LEAST** in the past week.

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

**3.** **Please rate your pain** by **circling** the one number that best describes **your pain** on the **AVERAGE**.

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

**4.** **Please rate your pain** by **circling** the one number that tells how much **pain** you have **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

**5.** Circle the one number that describes how during the past week, **PAIN** HAS **INTERFERED** with **your:**

**A.** General activity

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

**B.** Mood

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

**C.** Walking ability

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

**D.** Normal work (includes work both outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

**E.** Relationships with other people

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

**F.** Sleep

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

**G.** Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

**6.** What treatments or medications are you receiving for your pain? ____________________

______________________________________________

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# 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 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.

______________________________
Name (Please Print)

______________________________ Date: ____________ 20____
Signature of patient (or legal guardian)

______________________________ Date: ____________20____
Signature of Chiropractor

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**INFORMED CONSENT TO MASSAGE CARE:**

I hereby request and consent to the performance of massage therapy by any of the registered massage therapist working in the clinic, Keith Folkerts, Heather Groot, Marianne Cottingham, Curtis Moon and Alanna Augustin. I have had an opportunity to discuss with her and/or other office or clinic personnel, the nature and purpose of my treatment. I understand the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment, including but not limited to, muscle soreness, possible bruising, joint sprains and strokes. I do not expect the RMT to be able to anticipate and explain all risks and complications and I wish to rely on the therapist to exercise judgement during the course of the treatment which the RMT feels at the time, based upon the facts then known is in my best interests.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

**Please Note:** Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

Patient's Name ___________________ Signature of Patient/Guardian __________________________

Date ____________________________ Witnessed __________________________________________