RENEWing your Health… *Naturally*

Welcome to Core Health Centre and thank you for the opportunity to help you with your health. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly.

Date _____, 20___

Last Name _____ First Name _____ Init. ____ ❍ female ❍ male

Date of Birth _____ Age _____ Height ____'____" Weight _____ lbs.
M / D / Y

Address _____ Postal Code _____

Phone (home) _____ (work) _____ (cell) _____

(email) _____

Occupation _____ Employer _____

❍ Single ❍ Married ❍ Common law ❍ Separated ❍ Divorced ❍ Widowed

Name of Spouse _____ # of children _____

Alberta Health Care # _____ If under 18, name of parent or guardian _____

Emergency contact _____ Phone _____

Is this the result of a workplace incident/accident? ❍ yes ❍ no
Does your extended health plan cover chiropractic care? ❍ yes ❍ no

We appreciate those who refer their friends and family to our office. Please let us know who referred you to our care.

Name _____ Relationship to you _____

If you weren't referred, how did you hear about us? _____

How can we help?

Clients come to Core Health Centre for a variety of reasons. How do you hope to benefit from care in our office?
(Please check one or more responses)

❍ **Relief Care** **temporary relief of the pain or discomfort**

❍ **Corrective Care** **relieve the pain and symptoms and begin to address the underlying cause of the problem**

❍ **Wellness Care** **maintain the correction through regular preventative care and develop a wellness lifestyle**

Chiropractic History

Have you ever had your spine or nervous system examined by a chiropractor or other health professional? ❍ **yes** ❍ **no**
When? _____ **and by whom?** _____

Have you ever received a spinal adjustment by a chiropractor? ❍ **yes** ❍ **no**
If yes, by whom? _____ **and when was your last visit?** _____

What were the results of your care? _____

How long were you receiving chiropractic care? _____ **weeks** _____ **months** _____ **years**

What was your reason for discontinuing care? _____

Current Health Concerns

Do you have a major complaint? ❍ **yes** ❍ **no**
If yes, please describe _____
_____

Have you experienced this before? ❍ **yes** ❍ **no**
If yes, please describe _____

When did your major complaint or pain begin? _____

Is it getting: ❍ **better** ❍ **worse** ❍ **no change** ❍ **comes and goes** ❍ **other** _____

What aggravates your condition? ❍ **sitting** ❍ **standing** ❍ **walking** ❍ **running** ❍ **sleep** ❍ **work**
❍ **exercise** ❍ **stretching** ❍ **driving** ❍ **other, please describe** _____

What relieves or improves your condition? ❍ **ice** ❍ **heat** ❍ **activity** ❍ **rest** ❍ **sitting** ❍ **standing**
❍ **exercise** ❍ **stretching** ❍ **drugs** ❍ **other, please describe** _____

Is your pain or symptoms : ❍ **sharp** ❍ **dull** ❍ **burning** ❍ **stiff** ❍ **tight** ❍ **throbbing** ❍ **tingling**
❍ **numb** ❍ **other, please describe** _____

Are you experiencing pain or numbness in your: ❍ **arms** ❍ **hands** ❍ **head** ❍ **buttocks** ❍ **legs** ❍ **feet**

Are you presently taking: ❍ **pain killers** ❍ **anti-inflammatory** ❍ **muscle relaxants** ❍ **high blood pressure**
❍ **tranquilizers** ❍ **insulin** ❍ **birth control** ❍ **other** _____

Do you wear: ❍ **orthotics** ❍ **heel lifts**

What do you believe is wrong? _____
_____

Have you seen any other health provider regarding this complaint? ❍ **yes** ❍ **no**
If so, who? _____ **and when?** _____
What were the results? _____

Have you had any personal injuries or motor vehicle accidents? ❍ **none** ❍ **past year** ❍ **1 – 5 years** ❍ **>5 years**

FEMALES ONLY: Is there a possibility that you may be pregnant? ❍ **yes** ❍ **no**

If yes, how many weeks? _____**wks** **Is this your** ❍ **1st** ❍ **2nd** ❍ **3rd** ❍ **4th or more** **pregnancy?**

Have you had any difficulties with pregnancies in the past?
_____

Please indicate whether you have had a significant problem with any of the symptoms or conditions listed below. If it is a recurring problem please also indicate the ranges of years in which it happened.

	Not Applicable	10+yrs ago	1-10 yrs ago	within past year	currently experiencing	recurring
Asthma	❍	❍	❍	❍	❍	❍
Allergies	❍	❍	❍	❍	❍	❍
Dizziness/Fainting	❍	❍	❍	❍	❍	❍
Chronic Fatigue	❍	❍	❍	❍	❍	❍
Headache	❍	❍	❍	❍	❍	❍
Arthritis	❍	❍	❍	❍	❍	❍
Herniated Disc	❍	❍	❍	❍	❍	❍
Scoliosis	❍	❍	❍	❍	❍	❍
Seizures/Epilepsy	❍	❍	❍	❍	❍	❍
Stroke	❍	❍	❍	❍	❍	❍
Heart Disease	❍	❍	❍	❍	❍	❍
High Blood Pressure	❍	❍	❍	❍	❍	❍
High Cholesterol	❍	❍	❍	❍	❍	❍
Diabetes	❍	❍	❍	❍	❍	❍
Gall bladder	❍	❍	❍	❍	❍	❍
Liver	❍	❍	❍	❍	❍	❍
Ulcers	❍	❍	❍	❍	❍	❍
Diarrhea/Constipation	❍	❍	❍	❍	❍	❍
Irritable Bowel	❍	❍	❍	❍	❍	❍
Kidney problems	❍	❍	❍	❍	❍	❍
Frequent urination	❍	❍	❍	❍	❍	❍
Thyroid disease	❍	❍	❍	❍	❍	❍
Chronic lung disease	❍	❍	❍	❍	❍	❍
Ear or Hearing Problems	❍	❍	❍	❍	❍	❍
Visual problems	❍	❍	❍	❍	❍	❍
Circulation	❍	❍	❍	❍	❍	❍
Cancer	❍	❍	❍	❍	❍	❍
Other _____	❍	❍	❍	❍	❍	❍

Family Health History

Name	Relation	Past & Present Health Condition

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