CARLISLE FAMILY
CHIROPRACTIC
Maximizing your health, naturally.

Full Name: _____ Date: _____
Date of Birth: (dd/mm/yr) _____ Age: _____
Address: _____ Home Phone: _____
(Town) _____ Work Phone: _____
(Postal Code) _____ Gender: ☐ M ☐ F ☐ Prefer not to answer
Email Address: _____
☐ I would ***NOT*** like to be added to your email database to receive newsletters and other relevant health information

Marital Status: ☐ S ☐ M ☐ D ☐W
Do you have children? ☐Y ☐N If so, what are their ages? _____
Who may we thank for referring you to our office? _____
Have you received chiropractic care before? ☐Y ☐N
Who did you see? _____ For how long? _____
Were you happy with the results?
_____

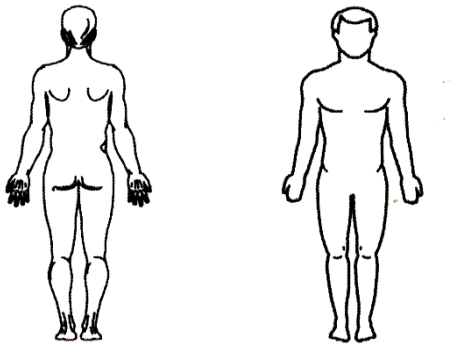
Part 1: Your Present Health Concerns

What are your ***health goals*** and ***expectations*** for your chiropractic care?

☐ Improve overall health, energy & vitality
☐ Less sick days away from work or school
☐ Improve quality of sleep
☐ Improve athletic performance
☐ Learning information about healthy lifestyle choices
☐ Optimal growth & development for my kids or family
☐ Decrease pain & improve day to day functioning
☐ Other: _____

If you have no symptoms or complaints, and are here for WELLNESS care, please skip to Part 2.

On the diagram below, please DRAW where you feel the concern, pain, or symptom(s) are located.



Please check all the descriptor(s) that describe what you feel in relation to your current condition:

☐ Sharp
☐ Dull
☐ Achy
☐ Burning
☐ Numbness
☐ Tingling
☐ Other: _____
☐ Shooting
☐ Cool/Cold
☐ Stiffness
☐ Tightness
☐ Tension
☐ Stabbing

If you are experiencing pain, please rate the severity of the pain on the following scale (circle a number).

0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Does the pain radiate or travel anywhere (ie. Down the arm or leg)? _____

When and how did this condition start? _____

How often does this bother you? ☐ Constantly ☐ Off and On ☐ Occasionally

Describe anything that aggravates or worsens your condition. _____

Describe anything that provides relief from your condition. _____

Have you had treatment for this condition? ☐ Y ☐ N If yes, what? _____

Please check the following area(s) where you feel your current pain or health concern affects you.

☐ Work	☐ Personal Care (bathing etc. . .)	☐ Sitting
☐ Social Life	☐ Recreation / Play	☐ Sleep/Ability to Rest
☐ Family Life	☐ Walking	☐ Relationships

Comments: _____

Part 2: Your Health Profile

Please list any medications you are currently taking, or have taken regularly in the past.
(women only: please include oral contraceptives)

Please list any nutritional supplements, herbs, or vitamins you take regularly.

Name of your family physician: _____ Date of last visit _____

YOUR CHILDHOOD YEARS

	YES	NO	UNSURE	COMMENTS
Did you have any childhood illnesses?	☐	☐	☐	_____
Did you have any serious falls as a child?	☐	☐	☐	_____
Did you take / use any drugs?	☐	☐	☐	_____
Did you have any surgery?	☐	☐	☐	_____
Have you fallen or jumped from a height over 3 feet?	☐	☐	☐	_____
Were you involved in any car accidents as a child?	☐	☐	☐	_____
Was there any prolonged used of medicine such as antibiotics or inhalers?	☐	☐	☐	_____
Did you suffer any other traumas (physical or emotional)?	☐	☐	☐	_____
As a child, were you under regular chiropractic care?	☐	☐	☐	_____

YOUR ADULT YEARS

	YES	NO	COMMENTS
Do / did you smoke? If yes, how many per day?	☐	☐	_____
Do / did you drink alcohol?	☐	☐	_____
Have you been in any accidents?	☐	☐	_____
Have you had any surgery?	☐	☐	_____
Do / did you play any adult sports?	☐	☐	_____

Has any member of your immediate family ever been diagnosed with any of the following conditions?

☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Stroke ☐ High Blood Pressure ☐ Arthritis

On a scale of Poor, Good, or Excellent, please describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Part 3: Stress Survey

On a scale of 1 to 10 (1 = None, 10 = Extreme) please rate your stress levels in the following areas:

___ Physical	___ Health Concerns	___ Body Image
___ Family	___ Occupation/School	___ Relationships
___ Dietary	___ Financial	___ Emotional Issues

Which, if any, of the following symptoms occur during times of elevated or increased stress in your life?

☐ Fatigue ☐ Muscle Tension ☐ Headaches ☐ Dizziness ☐ Gut Irritation ☐ Hyperventilation ☐ Increased pain

When you feel stressed, what do you do to calm yourself? _____

Part 4: General Symptoms – Past and Present

Please check any of the following that you have experienced *in the past year*.

GENERAL
☐ Headaches
☐ Fever
☐ Night Sweats
☐ Fainting
☐ Dizziness
☐ Loss of Sleep
☐ Loss of Weight
☐ Depression
☐ Anxiety
☐ Numbness
☐ Tingling

E.E.N.T
☐ Blurred vision
☐ Earache
☐ Deafness
☐ Ear infections
☐ Ringing in the ears
☐ Allergies
☐ Enlarged thyroid
☐ Frequent colds
☐ Sinus infections
☐ Enlarged glands

GENITOURINARY
☐ Trouble urinating
☐ Frequent urination
☐ Blood in the urine
☐ Kidney infection
☐ Bedwetting
☐ Prostate trouble

CARDIOVASCULAR
☐ High blood pressure
☐ Angina, chest pain
☐ Poor circulation
☐ Bleeding disorder
☐ Stroke
☐ Varicose veins
☐ Heart disease

SKIN
☐ Rashes
☐ Itching
☐ Burning
☐ Hives
☐ Eczema

MUSCULOSKELETAL
☐ Swollen joints
☐ Arthritis
☐ Weakness
☐ Neck, Back pain
☐ Shoulder pain
☐ Hip pain
☐ Knee, Ankle pain
☐ Foot pain
☐ Hand pain
☐ Elbow, Wrist pain

RESPIRATORY
☐ Difficulty breathing
☐ Chronic cough
☐ Excess phlegm
☐ Spitting up blood
☐ Chest pain
☐ Asthma

GASTROINTESTINAL
☐ Heartburn
☐ Indigestion
☐ Gas, bloating
☐ Nausea
☐ Ulcer
☐ Diarrhea
☐ Constipation
☐ Abdominal pain
☐ Gallbladder disorder
☐ Diabetes

FOR WOMEN ONLY
☐ Heavy menstrual flow
☐ Hot flashes
☐ Irregular cycle
☐ Cramps, backache
☐ Mood swings
☐ Painful breasts
☐ Lump(s) in breast

Do you have any other health issues you wish to discuss at this time?

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;

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.

Date: _____

_____ _____

Patient Signature (Legal Guardian) Witness of Signature

_____ _____

Please Print Name Please Print Name