# Chiropractic Intake

## Confidential Patient Information

First Name:___________________________________ Last Name:_________________________________________

Date of Birth (DD/MM/YYYY)____________________ Age:______________

Address: ____________________________________ City: _____________Province: ______ Postal Code:__________

Phone (home):____________________work:______________________ cell:___________________________________

Marital Status:______________ Occupation:_________________________ Employer:___________________________

Height:________________________________________ Weight:_____________________________________________

How did you hear about the clinic (or who)?_____________________________________________________________

Have you ever received Chiropractic Care? If so, when/who _______________________________________________

## Reason for Visit

What is your major current complaint(s)? _______________________________________________________________

When did this start/how long? _______________________________________________________________________

Have you had similar condition on the past? If Yes, When? _________________________________________________

Are you experiencing any numbness or tingling? If Yes, Where?______________________________________________

What activities aggravate your complaint? ______________________________________________________________

Other Doctors/ Therapists seen for this condition? ________________________________________________________

Have you had x-rays taken? __________________________________________________________________________

Is this condition a result of a motor vehicle or work related accident? _______________________________________

## Current Medical Information

**(Please check if you have now or had in the past)**

| | | | | | |
|---|---|---|---|---|---|
| Headaches | ☐ | Pins & Needles in legs | ☐ | Fainting | ☐ |
| Neck pain | ☐ | Pins & Needles in arms | ☐ | Loss of smell | ☐ |
| Sleeping Problems | ☐ | Numbness in fingers | ☐ | Loss of taste | ☐ |
| Back pain | ☐ | Numbness in toes | ☐ | Diarrhea | ☐ |
| Nervousness | ☐ | Shortness of breath | ☐ | Cold feet | ☐ |
| Tension | ☐ | Fatigue | ☐ | Cold Hands | ☐ |
| Irritability | ☐ | Depression | ☐ | Stomach upset | ☐ |
| Chest pain | ☐ | Lights bother eyes | ☐ | Constipation | ☐ |
| Dizziness | ☐ | Loss of memory | ☐ | Cold sweats | ☐ |
| Face flushed | ☐ | Ringing in the ears | ☐ | Loss of balance | ☐ |

Family Physician Name and address: ________________________________________________________________

May we contact your physician? Yes ☐ No ☐ Last Physical Exam Date:______________________

Current medications:_______________________________________________________________________________

Past Serious Injuries:_____________________________________________________________________________

Past Surgeries/Hospitalizations: ____________________________________________________________________

Sport injuries? Traumas? Fractures? Sprains? __________________________________________________________

Allergies/Sensitivities? ____________________________________________________________________________

Number of Pregnancies (if applicable)? ______________________________________________________________

Do you Exercise? (What type?)_______________________________________________________________________

Do you smoke? _____________________________ Drink Alcohol?_______________________________________

Age of Mattress?____________________________________________________________________________________

Sleeping posture (side/stomach/back):_______________________________________________________________

Do you currently have custom foot orthotics? _________________________________________________________

## Family History

| | Father's Side | Mother's Side |
|---|---|---|
| Heart Disease | Yes ☐ | Yes ☐ |
| Arthritis | Yes ☐ | Yes ☐ |
| Cancer | Yes ☐ | Yes ☐ |
| Diabetes | Yes ☐ | Yes ☐ |
| Stroke | Yes ☐ | Yes ☐ |
| High Blood Pressure | Yes ☐ | Yes ☐ |
| Other | Yes ☐ | Yes ☐ |

## Accident Information (if Applicable)

Have you been an accident recently? (within the last year) Yes ☐ No ☐

Work ☐ Auto ☐ Other ☐ Date ______________ Nature of Accident ____________________________________

Did you experience any symptoms after the accident? What? ____________________________________________

Did you feel popping or tearing noise in back of your neck? Explain ________________________________________

Did you require post-accident hospitalization? _________________________________________________________

Where? _____________________________ When? __________________ X-rays Taken? ______________________

Have you lost days at work? ___________________________ Dates _________________________________________

Is insurance involved?______ Which company, address:____________________________________________________

_______________________________________________________________________________________________

Attorney's name, if any________________________ Claim #_________________________________________________

Comments (Office use only)__________________________________________________________________________

_______________________________________________________________________________________________

Have you been in an accident(s) in the past ? ( over 1 year ago ) Yes ☐ No ☐

Work ☐ Auto ☐ Other ☐ Date________________________

Details of the accidents(s) / Date(s) __________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

# 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