East Central Chiropractic & Rehabilitation Intake Form

Last Name:	First Name:	AHC Number:
Date of Birth: DD / MM / YYYY	Age:	Administrative Gender: M / F
Address:	City, Province:	Postal Code:
Phone (Home) ( )	Phone (Work) ( )	Phone (Cell) ( )
Email address:		

Emergency Contact Name:	Emergency Contact Phone ( )

Third Party Insurance Information	
Third Party Insurer Name:	
Policy Holder:	Relationship to Policy Holder:
Group/ Policy #:	ID/ Certificate #:

Please check all answers and fill in the blanks where appropriate.

Is this a work related injury or WCB claim? Yes No Has your employer been notified? Yes No
Is this a Motor Vehicle Accident (MVA)? Yes No On what date did the accident occur? _______

Reason(s) for appointment: ______________________________
When did your condition begin? ______________________________

Have you ever had similar problems? Yes No Have you ever been treated for this problem? Yes No
If yes, please describe what did or did not work for you: ______________________________
Have you had previous chiropractic care? Yes No Dr. ________________ Date: _______________
If yes, please describe what did or did not work for you: ______________________________

Have you had X-rays, MRI, blood work or other tests for this condition? Yes No Which tests, when? _____

____

Can you perform daily home activities? Yes Yes, but only with help Not at all
Can you perform your daily work activities? All activities Only some activities Not at all
What is your occupation & regular duties? ______________________________
Describe your stress level None Mild Moderate High
Do you exercise? Yes No What kinds of exercise do you do? ______________________________

Family doctor name: Dr. ______________________________
Do you give consent to allow us to contact your medical doctor/clinic if needed? Yes No
Height: ______________ Weight: ______________ Blood Pressure: ______________

Name: *(please print)*

Please list all previous surgeries, traumas, illnesses, injuries, accidents (including motor vehicle accidents):

____

____

Please list all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: ____

____

____

Please list all allergies: ____

____

Personal & Family Medical History

Please circle if you or your immediate family (parents, grandparents, siblings) have had any of the following conditions:

Myself		**Family Member**	
Cancer	Heart Disease	Cancer	Heart Disease
Stroke	Diabetes	Stroke	Diabetes
Hypertension	High Cholesterol	Hypertension	High Cholesterol
Epilepsy	Other: ____________	Epilepsy	Other: ____________
None of the above		None of the above	

Is there any other relevant information you feel should be discussed? Yes No

Please describe:____

____

____

____

____

____

I concede that the above information is complete and correct to the best of my knowledge. I agree to notify my chiropractor at this clinic immediately of any health changes in the future

Date: ____________________ Patient signature: ____

Name: *(please print)*

Systems Review

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.
Put an “X” through each of the sections if you have not experienced any of the listed symptoms

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain	Allergies	

NEUROLOGICAL	CARDIOVASCULAR	GASTROINTESTINAL
Visual disturbance	Rapid beating heart	Poor/Loss appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting/dropping to floor	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Tremors	Pain over heart	Nausea
Headache	Hardening of arteries	Vomiting
Numbness	Swollen ankles	Constipation
Neuralgia (nerve pain)	Poor circulation	Diarrhea
Poor/loss coordination	Palpitations	Blood in stool
Weakness	Cold hand or feet	Gallbladder/jaundice
Concussion	Varicose veins	Colitis
	Bleeding disorder	

EYES, EARS, NOSE, THROAT	MUSCLE & JOINT	FOR WOMEN ONLY
Eye pain	Neck pain	Painful menstruation
Double vision	Jaw pain	Hot flashes
Blurred vision	Low back pain	Irregular cycle
Ringing in ears	Mid-back pain (between shoulders)	Cramps or back pain
Deafness/hearing problems	Arm/hand pain	Vaginal discharge
Nosebleeds	Shoulder pain	Nipple discharge
Trouble speaking/swallowing	Leg pain	Lumps in breast
Hoarseness	Knee pain	Menopausal symptoms
Sinus infection	Ankle/foot pain	Birth control pills
Nasal drainage	Pain/numbness down arms or legs	Miscarriages
Enlarged glands	Swollen joints	Complications with pregnancy
	Spinal curvature	Pregnant? Y / N
	Arthritis (osteoarthritis, rheumatoid arthritis, gout)	Other:
	Fractures	

MISCELLANEOUS
Depression
Anxiety
Diabetes
Infection
Hepatitis A/B/C
HIV/AIDS
Rashes/ itches
Psychological disorder

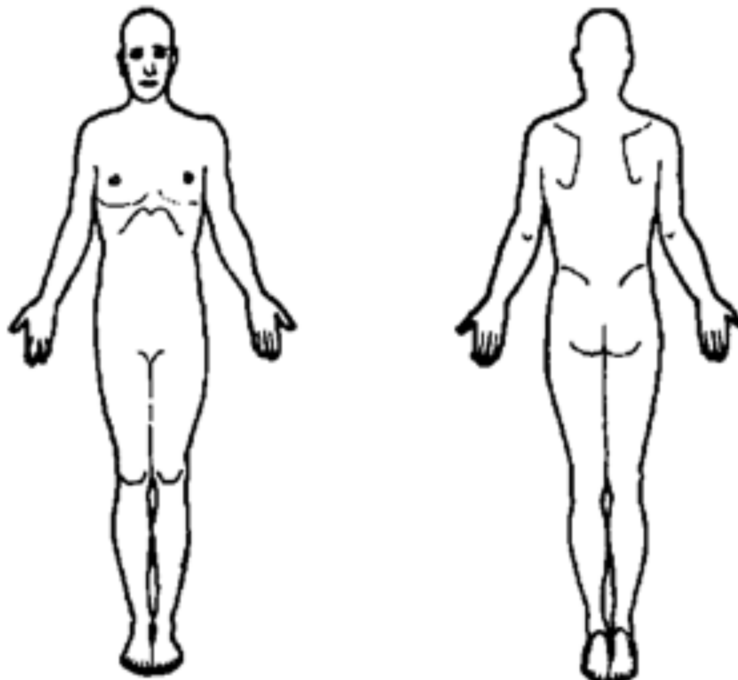
Name: *(please print)*

Health History Questionnaire

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure --Yes --No
2. Hardening of the arteries (arteriosclerosis) ----------------------------Yes --No
3. Diabetes --Yes --No
4. Tuberculosis ---Yes --No
5. Cancer --Yes --No
   Where? ____
6. Heart or blood diseases --Yes --No
7. Bone spurs on the neck bones (cervical sprain) ------------------------Yes --No
8. Whiplash injury (flexion-extension injury, cervical sprain)-----------Yes --No
9. Have you or any of your relatives ever suffered a stroke? -----------Yes --No
10. Were you ever a smoker? --Yes --No
    From _________________ to _______________
11. Do you take medication on a regular basis? ----------------------------Yes --No
12. Visual disturbances (blurring, loss, double vision)---------------------Yes --No
13. Hearing disturbances (loss, ringing, other noise) ---------------------Yes --No
14. Slurred speech or other speech problems -----------------------------Yes --No
15. Difficulty swallowing ---Yes --No
16. Dizziness -- --Yes --No
17. Loss of consciousness, even momentary blackouts -------------------Yes --No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ---------Yes --No
19. Sudden collapse without loss of consciousness-------------------------Yes --No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain — Extreme pain

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 the 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 degeneration 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 activities, may aggravated the disc condition.
  The consequence 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 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 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 of an artery that was already damaged and the patient was progressing towards a stroke

when the patient consulted with a 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 with 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 alternatives to treatment. I hereby consent to chiropractic treatment as proposed.

____
Name (Please Print) Date: _______________20____

____
Signature of Patient (or legal guardian) Date: _______________20____

____
Signature of Chiropractor Date: _______________ 20____

East Central Chiropractic & Rehab Privacy Statement

East Central Chiropractic & Rehab (ECCR) maintains the confidentiality and privacy of individuals' personal and health information while collecting, using and disclosing information in compliance with the *Freedom of Information and Protection of Privacy Act and the Health Information Act.* ECCR supports the right of individuals or their authorized representatives to access and request corrections to their personal and health information, subject to any specific restrictions in applicable legislation.

ECCR will not collect, use or disclose personal or health information in any manner that is not in accordance with the *Freedom of Information and Protection of Privacy Act, the Health Information Act*, or its established policies.

ECCR may disclose personal or health information for approved purposes as authorized by the *Freedom of Information and Protection of Privacy Act or the Health Information Act.*

The ECCR external web site may collect personal or health information when you voluntarily complete any online appointment booking. Personal or health information collected will only be used for the stated purposes. Information is collected pursuant to section 33 of the *Freedom of Information and Protection of Privacy Act* and sections 18–24 of the *Health Information Act*, as applicable.

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Signature of Patient (or legal guardian) Date: _______________20____