Leduc Wellness Centre
Adult Chiropractic

Alberta Health Care No.: ____ ____ ____ ____ ____ - ____ ____ ____ ____

CONFIDENTIAL PATIENT HEALTH RECORD

Name: _____ Sex: ☐ Female ☐ Male

Address: _____

City/Province: _____ Postal Code: ___ ___ ___ - ___ ___ ___

Telephone: Residence: _____ Cell: _____

Email (appointment reminders and/or receipts): _____

Occupation/Employer: _____ Work #: _____

Age: _____ Date of Birth: _____/_____/_____
mm dd yr

If applicable, Spouse's name: _____

Emergency Contact: _____ Phone #: _____

Have you ever received chiropractic care? ☐ No ☐ Yes - If yes:

Where: _____ Approximate date of last visit: _____

Is this a Worker's Compensation Case? ☐ No ☐ Yes- Date of Accident? _____

Is this a Motor Vehicle Accident Case? ☐ No ☐ Yes- Date of Accident? _____

Whom may we thank for referring you to our office? _____

PLEASE READ:

INITIAL VISIT: ADULTS: $90 UNDER 18: $65
PER VISIT FEE: ADULT: $45 UNDER 18: $35

Fees are due at time of service unless other arrangements have been previously made.
A Cancellation Fee may be charged for late or cancelled appointments.

Signature: _____ Date: _____

For dependent children under 18, name of parent(s) /guardian: _____
Parent/guardian with custodial rights must sign.

About Your Health

There are many events that occur and habits that we pick up throughout our lifetime that can cause accumulated stress in the body and result in a loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a good understanding of your overall health, both past and present, and allow us to better assess your body's ability to be healthy.

Current State of Health for: _____

(Patient Name)

Reason for consulting our office today:

- ☐ Health and spinal check-up?
- ☐ Correct and/or prevent an existing problem? *Please fill out the information below.*

Describe your symptoms and/or main problem: _____

_____

How and when did this problem start? _____

_____

How often are your symptoms present?

- ☐ constantly (75-100% of time)
- ☐ frequently (50-75% of time)
- ☐ occasionally (<50% of time)
- ☐ intermittently (comes and goes)

Please check the words that describe your pain/symptoms:

- ☐ sharp
- ☐ dull/aching
- ☐ throbbing
- ☐ radiating, *where?* _____
- ☐ numbness/tingling
- ☐ burning
- ☐ shooting

Circle the number below which <u>best describes</u> the intensity of your pain. If it varies, circle the numbers which describe the symptoms at their best and worst.

1 2 3 4 5 6 7 8 9 10

very mild pain — moderate pain — severe pain — worst pain

Since the problem started, is it: ☐ getting better ☐ getting worse ☐ about the same?

Does the problem interfere with: ☐ sleep ☐ work ☐ routine ☐ other?_____ _____

What aggravates your problem/symptoms? _____

What relieves your problem/symptoms? _____

Please describe any treatments and /or tests done for this problem: _____

_____

Have you had x-rays taken of this area? ☐ No ☐ Yes, When? _____

Any other problems or complaints? *Briefly describe:* _____

_____

Health History

To give the Doctor a complete picture of your overall health, please check off **ANY** of the following symptoms you have EVER experienced, even if you don't think they are related to the current problem:

☐ headaches	☐ neck pain	☐ diarrhea/constipation	☐ low back/hip pain
☐ leg/knee/foot pain	☐ upper back pain	☐ arm/shoulder/wrist pain	☐ migraines
☐ dizziness	☐ chest pains	☐ buzzing/ringing in ears	☐ osteoporosis
☐ allergies	☐ sinus problems	☐ general fatigue	☐ frequent colds
☐ frequent nausea	☐ cold feet/hands	☐ heartburn/indigestion	☐ sexual dysfunction
☐ anxiousness	☐ miscarriage(s)	☐ menstrual pains/PMS	☐ breast pains
☐ arthritis	☐ sleep problems	☐ thyroid problems	☐ asthma
☐ IBS/Colitis	☐ painful urination	☐ stiffness in morning	☐ diabetes
☐ eczema	☐ frequent urination	☐ high cholesterol	☐ cancer
☐ numbness/tingling	☐ jaw pain	☐ liver/gall bladder problems	☐ depression

List all medications and supplements you are taking (include birth control pills): _____

_____

List any surgeries/hospitalizations and include when: _____

_____

List any car accidents and/or major falls/injuries and include when: _____

_____

Name of Family Medical Doctor_____

May we correspond with your MD regarding your care? ☐ Yes ☐ No

Do you have a family history of?

☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Diabetes

Is there anything else you would like us to know? _____

_____

Should your health benefit company contact us to confirm treatment dates may we give them that information? ☐ Yes ☐ No Please Initial _____

About Your Care

Chiropractic provides three types of care. The first is Initial Intensive Care, which corrects the most recent layers of damage/injury and usually reduces or eliminates the symptoms. Then begins Reconstructive Care, or spinal rehabilitation, which corrects the years of damage that occurred when there were few symptoms. And finally, Maintenance Care, which helps keep you healthy! Your Doctor will explain these options to you and help you choose the care that's right for you.

What do you hope to get from today's visit? Check all that apply.

☐ explanation of condition	☐ ability to resume/increase activity
☐ reduce symptoms	☐ learn what I can do to help
☐ prevent reoccurrence	☐ other: _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

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 <u>NOT</u> 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