Wellness First Physiotherapy and Chiropractic

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Confidential Consultation

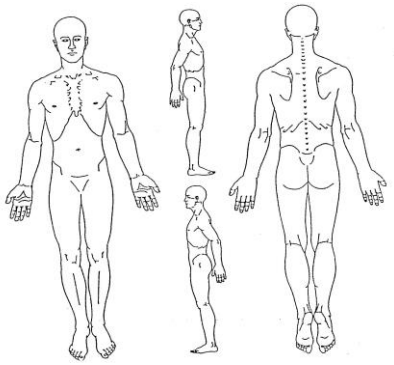
Name:			Date:
Address:		City:	Postal Code:
Home Phone: ( )	Work Phone: ( )	Date of Birth D M Y	Age: Sex: □Male □Female
Cell Phone: ( )	Email address:	How Did You Hear About Our Office?	
Occupation / Retired		Employer:	
Marital Status: □ single □ married □ widowed □ divorced □ common-law		Spouse's Name:	
Do you have children? □ yes □ no	What are their names / ages?		

What is your **main** complaint? _____

What actions have you taken, if any, to eliminate or reduce this health concern? _____

When did it start bothering you? _____

Was there any injury that caused the pain such as: fall ____ lifting_____ WSIB ___ other _____
or it just came on suddenly with no cause_____



Describe where pain is located and indicate on picture: _____

Has the pain gotten: Worse ____ Stayed the same_____ Better_____

Is the pain constant _____ Or does it come and go _____

How often do you get this pain if it comes and goes? _____

How long does it last for when you get the pain if it comes and goes? _____

On a scale of 0-10 what would you rate the pain at? (0 being no pain, 10 being the worst pain you can imagine) _____

How would you describe the pain? dull and achey _____ sharp and stabbing _____ burning_____
numbness and tingling _____ other____

What aggravates the pain or causes it to get worse? bending/twisting _____ lifting _____
leaning backwards _____ other_____

What relieves the pain if anything? Chiropractic_____ Massage_____ Physiotherapy_____
Medication_____ Exercise_____ Rest_____ other____

Is there any radiation of pain/burning_____ numbness and tingling down the arms_____ legs_____
around the chest_____ other_____ No _____

If the complaint does radiate down the legs or arms, which part of the leg/arm (inside___ outside___
back___ front____)

If it goes down into the fingers/toes than which ones _____

When you cough or sneeze does it aggravate the pain? Yes_____ No_____

Is there any pain that wakes you up from a dead sleep? Yes_____ No_____

Have you experienced unexplained severe weight loss or gain lately? Yes_____ No_____

Is there any blurred vision___ balance____ fainting___ buzzing in ears____
recent infections (fever, rash, etc)_____

Are there any other things that you have noticed in your health since the pain started?
_____

Is there any **family history** of: osteoporosis ___ diabetes___ heart disease____ arteriosclerosis____
stroke_____ cancer_____ Other _____ (please specify) _____

Do **you** suffer from any of the following:
bowel trouble___ bladder trouble___ Stomach troubles___ lack of energy ___ chronic illness ___
childhood illness ___ joint problems ___ heart problems___ blood problems ___ respiratory ___
other _____

Surgeries / Medical Care: _____

Medications: _____

Family Doctor: _____ Tel: _____ □No Family Doctor

Previous Chiropractic Care: Yes □ No □ Approx date of last visit ? _____ Dr. _____

X – Rays taken in last 12 months: Body part: _____

Pregnant: Yes □ No □ Unsure □

Other Tests (MRI, CT, Ultrasound, etc) _____

This case history allows us to uncover the stresses to your body that have accumulated over a lifetime. Such stresses include physical stresses (injuries, accidents, postural strains, etc), chemical stresses and emotional stresses. These stresses result in damage to your nervous system.

Health Influences
Cigarettes? Yes □ No □ If yes, # Cigarettes //week: _____ Alcohol: # drinks /week: _____
Water: # glasses / day: ____ Exercise: _____ times / wk
Sleeping Posture: Side □ Stomach □ Back □ Sleep per night: ____ hrs.

Please List Strains, Sprains, Broken Bones, Car Accidents, Falls, Injuries and Other Traumas Experienced Since Birth.

1) _____ 2) _____

3) _____ 4) _____

How concerned are you that your health will worsen over time?

(Circle) 1 2 3 4 5 6 7 8 9 10
Marginally Moderately Extremely

On a scale of 1 to 10, what is your commitment to improving your health?

(Circle) 1 2 3 4 5 6 7 8 9 10
Very Low Moderate Very High

Do you have insurance? Yes □ No □

Is **Chiropractic** Covered? Yes □ No □ How much per year? _____
What is your calendar year? _____ Is it combined with any other service? Yes □ No □

Is **Physiotherapy** Covered? Yes □ No □ How much per year? _____
What is your calendar year? _____ Is it combined with any other service? Yes □ No □

INFORMED CONSENT AND TERMS OF ACCEPTANCE

Please read the following and sign at the bottom. Please note that the following information is provided to you in advance so that if yours is a chiropractic case, and if you consent to receive care, you are aware of this information.

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care it is essential that both are working toward the same goal. Chiropractic care does not diagnose or treat disease**. Chiropractic has only one goal and this is to locate, analyze and correct spinal and other misalignments (subluxations) that interfere with nervous system function.** The purpose of the nervous system is to control and co-ordinate all bodily functions. Interference to the nervous system (master system) causes improper function in the body. Correction of misalignment (subluxation) through specific chiropractic adjustment and specific spinal rehabilitation procedures allows the body to optimize its functional capacity and thereby optimize its ability to heal, restore and maintain health. .

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of my chiropractic treatment (including spinal adjustment) as well as the contents of this consent. I understand that, as in all health care, results are not guaranteed as every person is unique.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be effective treatment for many conditions and to contribute to overall well being.

There are risks with all health care procedures and one must appreciate there is also risk with regular activities of daily living such as walking, driving, etc. I understand that any risks from chiropractic treatment are substantially lower than that associated with many medical treatments, medications and many other health procedures. The practice of chiropractic care has some slight and minimal risks that include, but are not limited to rare instances of minor symptomatic aggravation, rib fracture, muscle strain and rare reported instances of disc injury following cervical and lumbar spinal adjustment (although no scientific study has ever demonstrated disc injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment).

There are reported cases of stroke associated with common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being informed of this possible association because stroke sometimes causes serious neurological impairment. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications, however remote. I wish to rely on the doctor to exercise judgement during the course of care and to use procedures which the doctor feels, based on the facts, then known, are in my best interests.

I understand that the adjustments offered in this office are not a replacement for any form of treatment provided by other types of practitioners. I understand that I am not being treated for any disease, symptom or condition other than misalignment (subluxation) correction. This office offers chiropractic as a form of health and wellness care to promote the natural mechanisms of self-healing. I understand that any nutritional advice given in this office is for nutritional and lifestyle information only and that the information provided is not intended to diagnose, treat, cure or prevent any disease(s).

I request and consent to the recommended chiropractic procedures including examination, diagnostic imaging (if necessary), spinal adjustments, modalities, exercise or other rehabilitative procedures to support my healing. This consent is provided to the doctor as well as staff working under the authorization of the doctor.

Dated this _____ day of _____, 20____.

_____
Legal Guardian signature (if applicable)

_____ _____
Patient Signature

_____
Witness (signature)

_____ _____
Patient name (print)

_____
Witness (Print)