



Chiropractic Health Care

Welcome to DOWNTOWN INTEGRATIVE HEALTH GROUP and thank you for the opportunity to help you with your health. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly.

PERSONAL INFORMATION

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Phone: Home _____ Business _____ Cell _____

E-mail _____ Alberta Health Card Number _____ - _____

Date of Birth (D/M/Y) _____ Age _____ Male [] Female []

Occupation _____ Employer _____

Contact Person _____ Their phone number _____

Do you have extended health care benefits? Yes No With whom? _____

Is this a Workers Compensation Board injury? Yes No

Are your injuries related to a Motor Vehicle Accident? Yes No

We appreciate those who refer their friends and family to our office. Please let us know who referred you to our care. Name
_____ Relationship to you _____

If you weren't referred, how did you hear about us? M.D. Website Sign Phone Book

Other _____

**Although our office does not direct bill third party insurance coverage, we do encourage our patients to check their benefit package regarding their coverage for the following services: chiropractic, naturopathy, TCM, acupuncture, massage therapy, orthotics, exercise therapy. We will issue you receipts that you can submit for reimbursement.*

CURRENT HEALTH CONCERNS

What are the most important health concerns for which you are seeking treatment from us or are receiving elsewhere?

List in order of importance to you.

1. _____
2. _____
3. _____

What do you hope to gain from your treatment here? Check all that apply:

Pain reduction Return of function Guidance for future prevention Other: _____

Health Providers *Who else have you seen regarding your health and when was your last visit?*

- | | |
|---|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Naturopathic Doctor |
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Homeopath |
| <input type="checkbox"/> Traditional Chinese Medical Practitioner | <input type="checkbox"/> other |

Last Visit _____ Name of your Medical Doctor: _____

Please list any prescription and non- prescription medications, vitamins and other supplements, the dosage and reason for using them.

1. _____
2. _____
3. _____
4. _____

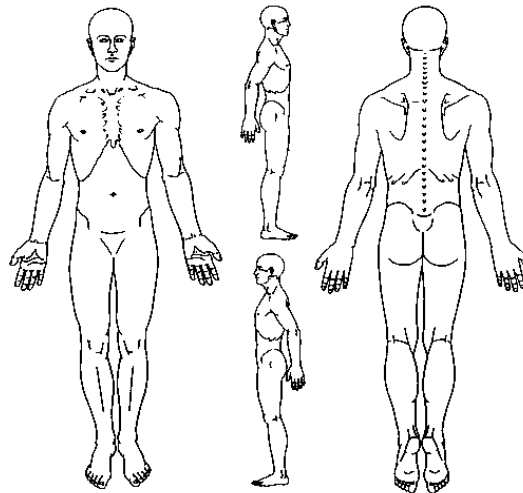
Please list any serious illnesses, surgeries, auto or sports injuries or broken bones
 _____ when _____

Have your reached full recovery? **Y N**
 _____ when _____

Have your reached full recovery? **Y N**
 _____ when _____

Have your reached full recovery? **Y N**

On the diagram(s) below, please circle the area(s) that applies most to where you experience symptoms or feel pain.



Use these letters to describe the pain: **S** sharp **D** dull **A** achy **H** hot **C** cold **N** numb **T** tingling **DB** deep and boring **TW** twisting **V** variable

How bad is the pain at its **LOWEST** and **HIGHEST** (no pain) 0-1-2-3-4-5-6-7-8-9-10 (worst pain ever)

When and how did it start? _____



HEALTH LIFE STYLE INFORMATION

Your health is influenced by many factors. Your answers to the following questions are important and will be kept totally confidential.

Weight : _____ Weight 1 year ago: _____ Max weight: _____ Height : _____ Blood type:
O A AB B Don't know

Rate your energy level: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate your quality of sleep: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate your stress level: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Do you currently wear orthotics? Yes No Do you wear a dental splint? Yes No

What are your primary physical activities?

1. _____
2. _____
3. _____

How would you describe your job? physically demanding with heavy lifting variety of sitting, standing and walking mostly sitting boring satisfying in transition

Do you smoke? Yes No How many per day? _____ How many years? _____

Chew tobacco? Yes No How many per day? _____ How many years? _____

Have you ever tried to stop? Yes No

Do you drink alcohol? Yes No How often? daily weekly infrequently

Do you use recreational drugs? Yes No How often? daily weekly infrequently

How often do you eat out per week? less than 3 between 4 and 8 over 9

What would you say about your diet? needs significant improvement ok for now very healthy

Do you drink coffee? Yes No How many cups/day? _____

Have you any diet preferences or restrictions? vegetarian celiac other: _____

Please list any drug, food, and environmental allergies or sensitivities.

Have you now or in the past had mercury dental fillings? Yes No Yes, but they're removed

Have you any surgical implants or piercing (medical or cosmetic)? Yes No

Please be specific: _____

Have you been vaccinated? Yes No Any adverse reactions? Yes No

How many times have you been on antibiotics in the past two years? _____

Do you have a history of drug or alcohol abuse? Yes No

REVIEW OF SYSTEMS

Please check the box if you are currently experiencing any of these symptoms.

- Mental/Emotional:** Mood swings Anxiety or nervousness Poor concentration
 Memory Problems Depression Anger
- Endocrine:** Thyroid disease Heat or Cold Intolerance Diabetes Sugar
 Sensitivities Fatigue Weight loss/Weight gain
- Immune:** Chronic Infections Chronic swollen glands Slow wound healing
 Frequent colds
- Skin:** Rashes Eczema, Hives Acne, Boils Itching
- Head:** Headaches Migraines Head Injury
- Ears:** Earaches Impaired Hearing Dizziness Ringing in Ears
- Nose and Sinuses:** Nosebleeds Seasonal Hay fever Sinus problems Loss of smell
- Mouth and Throat:** Frequent sore throat Sore tongue/lips Tonsils removed
 Change or loss of taste
- Respiratory:** Cough Wheezing Asthma Bronchitis Emphysema
 Chronic Phlegm Pneumonia
- Cardiovascular:** Heart disease High/Low Blood Pressure Palpitations
 Arrhythmia High Cholesterol Cold extremities
- Gastrointestinal:** Heartburn Belching or Passing Gas Change in thirst Change in Appetite
 Constipation Diarrhea
- How many bowel movements do you have per day? ____ Per week? ____
- Have you ever had parasites? **Yes** **No** **Don't know**
- Have you ever had a colonoscopy? **Yes** **No**
- Genital-urinary:** Difficulty with urination and/or frequent urination Frequent night time urination
 Incontinence Discharge or sores Chronic Infections
- Nervous System:** Numbness/pain in extremities Tingling in hands or feet Paralysis
- Musculoskeletal:** Joints: pain/swelling/stiffness
 Muscles: aches/cramps
 Spine: recurrent neck or back pain spreading pain to arms or legs

FAMILY HISTORY

Please check any of the following conditions that have occurred in your family (grandparents, parents, siblings).

Arthritis Alzheimer's Asthma Cancer Diabetes Eczema Heart Disease
Mental Illness Multiple Sclerosis Osteoporosis Parkinson's Thyroid Condition
Other _____

WOMEN'S HEALTH

Is there a chance you could be pregnant? Yes No

Number of previous pregnancies _____ Number of miscarriages/abortions _____

Have you ever used birth control? Yes No What type? _____ How long? _____

How many days do you bleed? _____ How long between your periods (onset to onset)? _____

Do you experience: Heavy flow Light flow Clotting Bleeding between periods

Cramping Pain during intercourse Low sex drive

Do you have pre-menstrual symptoms (PMS)? Yes No

Pain or cramping Mood Swings Bloating and/or water retention Headaches Breast tenderness

Cravings Other: _____

Have your periods stopped (menopause)? Yes No When? _____

Date of last bone density test _____ normal osteopenia osteoporosis

Date of last Pap test _____ normal abnormal

Do you perform monthly self-breast exams? Yes No

When was your last professional breast exam? _____

Do you have regular mammograms? Yes No

MEN'S HEALTH

Do you have any of the following?

Hernia Testicular mass and or pain Discharge or sores Impotence or erectile dysfunction Low sex drive Prostate condition

Do you perform self-testicular exams? Yes No

Year of last prostate exam? _____

Are there any other significant events that you believe have impacted your health?

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;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

CONSENT TO 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.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness Signature

Patient Name (please print)

Witness Name (please print)

CONSENT TO RELEASE INFORMATION

This clinic protects any information shared by our patients and will only release this information with your signed consent. If your treatment involves other clinicians, there is a benefit to you if they communicate relevant information. This may be done verbally or through accessing charts. Without a specific release, any personal (non-clinical) information will always remain confidential.

I hereby grant permission for the release of information among the clinicians of the Downtown Integrative Health Group and/or to my medical doctor and/or to my insurance company. This document is also my consent to provide and release all and any medical information including, but not limited to, hospital records, charts, nurses notes, x-rays, laboratory results, consultations, reports and any other documents forming part of my medical or chiropractic record and forward same to **Downtown Integrative Health Group**

Patient Signature (Legal Guardian)

Date:_____

Witness Signature

