



# Welcome

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## Personal Information

Last name \_\_\_\_\_ First name \_\_\_\_\_ M / F \_\_\_\_\_  
 I prefer to be called \_\_\_\_\_ Birthday (M/D/Y) / / Age \_\_\_\_\_  
 Address \_\_\_\_\_ Phone number \_\_\_\_\_  
 \_\_\_\_\_ Home \_\_\_\_\_  
 \_\_\_\_\_ Cell \_\_\_\_\_  
 City \_\_\_\_\_ Postal code \_\_\_\_\_ Work \_\_\_\_\_  
 Email \_\_\_\_\_

May we communicate with you via email (for things like appointment reminders and important information)

YES

NO

Marital status \_\_\_\_\_ Spouses Name \_\_\_\_\_

Children Y / N If yes, how many? \_\_\_\_\_ What are their names? \_\_\_\_\_

Your Occupation \_\_\_\_\_

## We would like to know more about you

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs / kgs

What are your health goals?

Hi - performance athletics

Wellness and health

Relief of pain and symptoms

Please expand on your health goals \_\_\_\_\_

Physical activities you do during the week \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

Avg. hours of sleep \_\_\_\_\_ hrs / night Consume caffeine Y / N Frequency \_\_\_\_\_ cups / day

Consume water Y/N \_\_\_\_\_ L / day

Is there any possibility you could be pregnant? Y / N Midwife Office: \_\_\_\_\_

How did you find us? (Who can we thank for referring you?) \_\_\_\_\_

Have you been under Chiropractic care before? Y / N If yes when? \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Care card number (MSP) \_\_\_\_\_

## ADMINISTRATIVE USE ONLY

Doctor has reviewed informed consent with patient

INITIAL

DATE

# Injury / Concern

## If your concern is due to injury or pain

Where is your concern located \_\_\_\_\_

When did it begin (date) \_\_\_\_\_

How did it begin \_\_\_\_\_

Does anything make it feel better \_\_\_\_\_

Does anything make it worse \_\_\_\_\_

Please describe your concern (aching, stabbing, numbness etc.) \_\_\_\_\_

Does it radiate or refer to another part of your body Y / N Where? \_\_\_\_\_

What is the severity of your concern? \_\_\_\_\_ 1-10 (1= virtually no pain / 10 = worst pain imaginable)

What time of the (day / week) is your concern worst \_\_\_\_\_

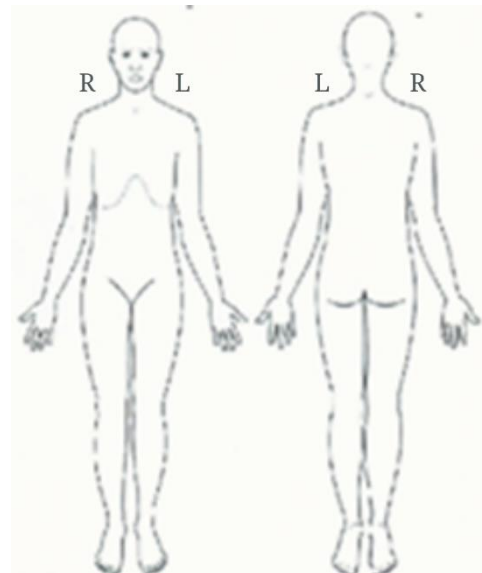
### PRESENTING SYMPTOMS

Please show areas of pain or unusual feeling

Mark the areas of the body where you feel the described sensations

Include all affected areas

Numbness	N
Pins and needles	P
Burning	B
Aching	A
Stabbing	S





# Health History

Have you ever suffered from? (please answer all questions)

Dizziness	Y / N	Constipation	Y / N
Heart trouble	Y / N	Diarrhea	Y / N
Diabetes	Y / N	Sinus trouble	Y / N
Arthritis	Y / N	Menstrual problems	Y / N
Headaches	Y / N	Cancer	Y / N
Migraines	Y / N	Chronic fatigue	Y / N
Asthma	Y / N	Sleeping difficulties	Y / N
Heart burn	Y / N	Depression	Y / N
Irritable bowels	Y / N	Ear noises	Y / N
Numbness	Y / N	Digestive problems	Y / N
Deafness	Y / N	High blood pressure	Y / N

Please list any operations (with dates) \_\_\_\_\_

Please list any illnesses (with dates) \_\_\_\_\_

Any other hospitalizations? \_\_\_\_\_

Please list any family health conditions (Arthritis, Diabetes, Cancer, Heart disease etc.) \_\_\_\_\_

Have you ever smoked? (list amount, frequency and duration) \_\_\_\_\_

Medications currently taking \_\_\_\_\_

Period of time taking above medications \_\_\_\_\_

Have you ever been knocked unconscious? \_\_\_\_\_

How long unconscious? \_\_\_\_\_

Is there anything else you feel the Doctor should know? \_\_\_\_\_

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## Patient Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including X-rays, if necessary, on me by the Doctor(s) of Chiropractic affiliated with me. I have had an opportunity to discuss with the doctor(s) of chiropractic, adjustments, and other procedures. Although I am expected to get great benefit from chiropractic care, I understand that the results are not guaranteed. I further understand and am informed that as in all health care, with certain chiropractic techniques, there are some very slight risks to treatment, including, but not limited to, muscle strains, and sprains, disc injuries and rib fractures. The possibility of an associated stroke with an upper cervical adjustment is extremely remote and un-established.

I do not expect the doctor to be able to anticipate all the risks and complications. I rely on the doctor's exercise of judgment which chiropractic procedure, based upon the facts known, is in my best interest. I have read this consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of current and future chiropractic care for which I seek treatment.

I understand that I am responsible for payment of all services and that they are to be paid in full at time service is rendered unless prior arrangements have been made.

### ***Missed Appointment and Cancellation Policy***

***Missed appointments or those who do not inform us of an appointment cancellation 24 hours prior to appointment time will be charged a \$60 fee. There is 24 hour / 7 day a week voicemail, text, and email for your convenience. Thank you.***

Please only read this consent form, to familiarize yourself with it.

**You will sign it once you have had a chance to discuss it with the Doctor.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Doctor to Witness)