

PATIENT INTRODUCTION FORM & CLINICAL RECORD

(please print)

Today's Date _____ 20__

Name _____ Marital Status S M W D

Address _____ Postal Code _____

Sex _____ Date of Birth _____ Age _____ Home Phone _____ Cell: _____

#Children _____ Age of Children _____ Occupation/Profession _____

Employed by _____ Business Phone _____

Husband or Wife's name _____ Family Physician _____

Have you had Chiropractic before? _____ By Whom? _____ When? _____

Referred by _____

Social Insurance: _____ Personal Health No: _____

Do you have reason to believe you may be pregnant? No _____ Yes _____ Due Date _____

Are you claiming under Worker's Compensation Act? No _____ Yes _____ Claim # _____

Are you claiming under I.C.B.C. ? No _____ Yes _____ Claim # _____

Briefly describe complaint: _____

Please mark your areas of pain on the figures shown here =>

Do you have:

Neck Pain _____

Headaches _____

Mid back pain _____

Pain in Arms _____

Trouble with Vision _____

Dizziness/Fainting _____

Fractured bones _____

Chest Pain _____

Diabetes/Kidney Problems _____

Disc Problems _____

Communicable disease? (AIDS, Hepatitis B) _____

Low Back Pain _____

Pain in Legs _____

Arthritis _____

Circulation Problems _____

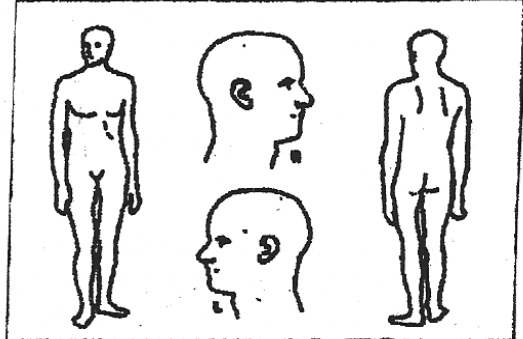
Pinched Nerves _____

Depression/Mental Illness Diagnosed _____

Heart Attack/ Stroke _____

Other Medical Condition _____

High Blood Pressure/High Cholesterol _____



If yes, please explain in detail: _____

Have you ever had any falls, accidents or injuries? Yes _____ No _____

If yes, please explain (give month & year) _____

Have you ever had any surgery? Yes _____ No _____

If yes, please give type & date (month & year) _____

Are you presently taking medication? Yes _____ No _____

If yes, please give type, dosage and reason _____

Medical Services Plan of British Columbia reduced Chiropractic coverage in 2001; - Status, 1st Nations and Income Assistance

Patients still have coverage.

Most Extended Medical Plans cover Chiropractic care. Keep your Receipt!

NSF CHEQUES \$40.00

Signature



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment **FORM L**

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.

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 of Signature

Name: _____
(please print)

Name: _____
(please print)

MR. MRS. MISS MS. _____ PATIENT# _____ DATE _____
BLOOD PRESSURE _____ PULSE _____ O2 LEVEL _____
BF% _____ WEIGHT _____ MSP _____

1. What is your reason for coming into the office today? Do you have recent trauma? Please describe (how did it happen)?
 2. When did it happen? What did you do for the problem?
 3. Where is the pain, today?
 4. Please describe your pain. (Stabbing, burning, etc) Grade it from 0 to 10
 5. Does the pain go down the arms, from behind the head to the front of the head, down the legs to the feet?
 6. How often do you have pain? Occasionally ____, 2-3 times/day ____, all day _____
 7. How long does your pain last?
 8. What types of activities aggravates your pain?
 9. What do types of things do you do to relieve the pain?
 10. Has your Dr. diagnosed you with any condition; past or current?
 11. What is your family history? (Are there genetic problems, or history of health problems?) (Cancer, diabetes, or heart?) What are the ages of your parents and siblings? What, if any, are the medical diagnosis for them?
Father ____ Age ____ Deceased? ____ Medical Condition _____
Mother ____ Age ____ Deceased? ____ Medical Condition _____
Siblings ____ Age ____ Deceased? ____ Medical Condition _____
- If need more space please ask for another piece of paper.
12. What drugs or chemicals (prescription or not) have you taken previously or are currently on?
 13. What do you do in your spare time (TV, computer games, sports, etc.)?
 14. Do you have any secondary complaints?

Dr.'s Notes:

Working Hypothesis: