ACQUAINTANCE INFORMATION

The data on this confidential form is essential if we are to render the best professional care.
We appreciate your co-operation in filling it out so that we will have accurate records.
Please Print - Thank You

PERSONAL INFORMATION

DATE				E-MAIL ADDRESS
PATIENT'S LAST NAME		FIRST NAME		HOME PHONE
HOME ADDRESS		CITY/TOWN		POSTAL CODE
DATE OF BIRTH DAY/MONTH/YEAR		OCCUPATION		BUSINESS PHONE
EMPLOYER		BUSINESS ADDRESS		
MARITAL STATUS	SEX	NAME OF SPOUSE	OCCUPATION	BUSINESS PHONE
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?			WHO MAY WE "THANK" FOR REFERRING YOU TO OUR OFFICE?	
NO. AND AGES OF CHILDREN		EMERGENCY CONTACT	NAME	PHONE

PROVINCIAL HEALTH CARE INSURANCE PLAN

ALBERTA HEALTH CARE NUMBER	SOCIAL INSURANCE NUMBER
OTHER HEALTH INSURANCE	PLAN/GROUP POLICY NUMBER

If you have no symptoms or complaints, and are here for wellness services, please check (✔) here _____ **"WISH TO HAVE CHIROPRACTIC WELLNESS SERVICES"** and skip to **"FAMILY HEALTH PROFILE"**. Others need to answer the following brief questions.

YOUR HEALTH PROFILE

Is this a work related injury? ❑ No ❑ Yes Is this a motor vehicle related injury? ❑ No ❑ Yes
Have you had previous Chiropractic care? ❑ No ❑ Yes Doctor _____ City _____
What were you treated for? _____ Were X-Rays taken? ❑ Yes ❑ No
What is your major complaint? _____
How long have you had this condition? _____
Is this condition getting progressively worse? ❑ No ❑ Yes When? _____
Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other _____
What activities aggravate your condition? _____
What makes it feel better? _____
Have you had this or a similar condition in the past? ❑ No ❑ Yes When? _____
Other complaints: *(please list)* _____

_____
How long has it been since you felt really good? _____
Please list any surgical operations: _____
And years they were performed _____
Name of medical doctor _____
Are you currently taking ❑ Birth Control Pills ❑ Insulin ❑ Muscle Relaxants ❑ Nerve Pills
❑ Pain Killers ❑ Pep Pills ❑ Tranquilizers ❑ Vitamins
Other medications _____

continued next page

YOUR HEALTH PROFILE (CONTINUED)

Age of mattress _____ ❑ Comfortable ❑ Uncomfortable

How do you sleep? ❑ On Back ❑ On Side ❑ On Stomach ❑ A Combination

Have you ever been in an auto accident? ❑ No ❑ Yes *(describe)* _____

_____

Have you had any other personal injury? ❑ Past Year ❑ Past 5 Years ❑ Over 5 Years ❑ None

Or accident? *(describe)* _____

Interest & Hobbies: _____

Smoke ❑ No ❑ Yes How Much? _____

What are your objectives in consulting this office? _____

_____

What are your health objectives once you feel better? _____

_____

Have you ever been to a doctor who put you on a health development program? ❑ No ❑ Yes

If yes, What was their name: _____

How long did you stay on the program? _____

What were the results? _____

Were the results permanent? ❑ No ❑ Yes

Are you as healthy today as you were 5 years ago? ❑ No ❑ Yes

If yes, what were your strategies? _____

_____

Do you plan to be healthier 5 years from now than you are today? ❑ No ❑ Yes

If yes, what strategies do you plan on implementing to do this? _____

_____

_____

_____

If no, what strategies could you implement? _____

_____

_____

_____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

Others _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diptheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

CHECK ANY OF THE FOLLOWING YOU **HAVE** OR **HAVE HAD** IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM CODE

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GENERAL CODE

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Changes
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

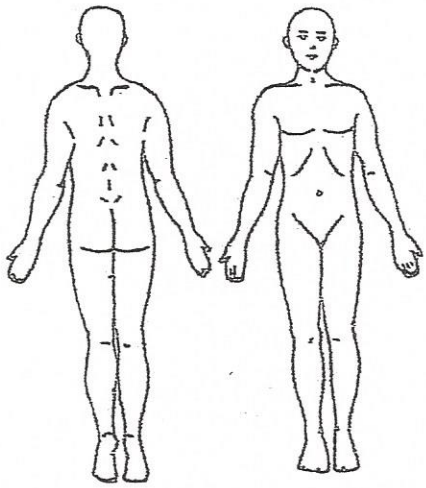
MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

FEMALES ONLY:

When was your last period? _____

Are you pregnant? ☐ Yes ☐ No ☐ Maybe



Please outline on the diagram the area of your discomfort.

WHY CHIROPRACTIC?

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ❑ Relief Care
- ❑ Corrective Care
- ❑ Comprehensive Care
- ❑ Check here if you want the Doctor to select the type of care appropriate for your condition.

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 througvh 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 NOT 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.

_____ Date: _____ 20_____.
Name (Please Print)

_____ Date: _____ 20_____.
Signature of patient (or legal guardian)

_____ Date: _____ 20_____.
Signature of Chiropractor