

ACCESS YOUR HEALTH CHIROPRACTIC & MASSAGE

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Chiropractic Patient Admittance Form (PLEASE PRINT AND BRING TO THE OFFICE)

PERSONAL INFORMATION

Last Name: _____ Given Name: _____ Initial: _____

Address: _____

City/Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

E-mail Address: _____

Date of Birth (D/MM/YYYY): _____ Male Female

Occupation: _____ Employer: _____

Contact Person: _____ Their Phone #: _____

Married Single Widowed Separated Common-Law Number of Children: _____

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

Policy #: _____ Group #: _____

We appreciate those who refer their friends, family and colleagues to our office. Please let us know who referred you to us!

Name: _____ Relationship to you: _____

If you weren't referred, how did you hear about us? _____

CURRENT HEALTH CONCERNS

Purpose of this appointment: _____

Other Doctor's seen for **this** condition/Date you saw them: _____

When did this condition begin? _____

If disabled from work, please give dates: _____

Job Related Auto-related Other Please explain: _____

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

Pain reduction Return to function Future prevention Comprehensive care

If you are interested in comprehensive care, please check the boxes that interest you:

Vitamins/minerals/supplements Information on nutrition Orthotics Sports performance

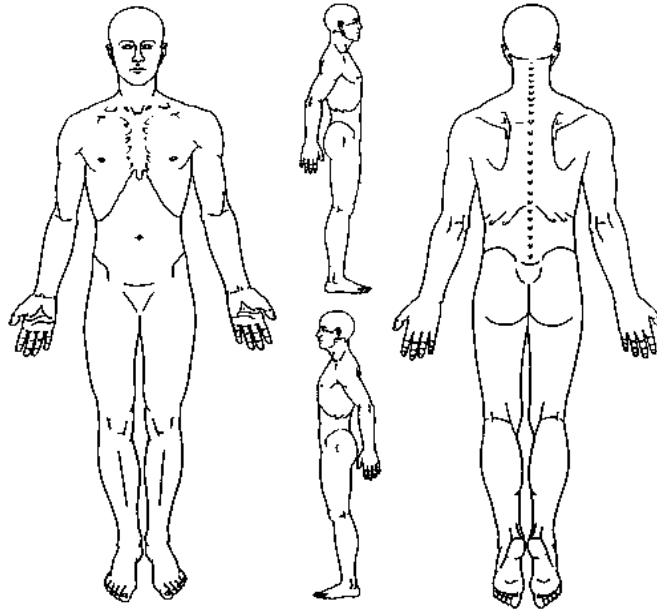
Have you been to a Chiropractor before? Yes No If so, who and when? _____

Name of Medical Doctor and last date of visit: _____

Please list any prescription and non-prescription medications, vitamins and supplements that you take and the reason for using them: _____

Please list any serious illnesses, surgeries, auto injuries, hospitalizations or broken bones: _____

On the diagrams below, please circle the area(s) that apply most to where you experience and/or feel the pain/discomfort:



REVIEW OF SYSTEMS

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

Mental/Emotional: Mood swings Anxiety/nervousness Poor Concentration
 Memory Problems Depression Anger

Endocrine: Thyroid Disease Heat/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 & sinuses: Nosebleeds Seasonal Hay fever Sinus problems Loss of smell

Mouth & 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/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

Genitourinary: 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/feet Paralysis

Musculoskeletal: Pain/swelling/stiffness in joints Muscle aches/cramp Recurrent back/neck pain Pain spreading into the arms and/or legs

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 long between your periods? _____

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

Have your periods stopped(menopause)? Yes No

Date of last bone density test _____ Normal Osteopenia Osteoporosis

Date of last pap test _____ Normal Abnormal

Do you perform monthly breast self-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 or pain Discharge or sores Impotence or erectile dysfunction Low sex drive Prostate condition
Do you perform testicular self-exams? Yes No

Date of last prostate exam? _____

Informed Consent to Chiropractic Treatment FORM L
Please read Carefully before signing

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. Recent studies suggest 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: _____ **Name:** _____

Informed Consent for Acupuncture Care FORM -AC
Please Read Carefully before signing

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the abovenamed doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed. I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

I intend this consent to apply to all my present and future acupuncture care.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____ Name: _____