Welcome to Adjust Your Health
Sports & Family Health Centre

In order for the Doctors and/or Practitioners to provide you with the best possible care the following confidential information must be completed.

Patients Name: _____ Date: _____
Last First

Address: _____
City Postal Code

Home Phone #:_____ Date of Birth: _____

Work Phone #:_____ Sex: Female Male

Alberta Health Care #_____ Marital Status: S M D W

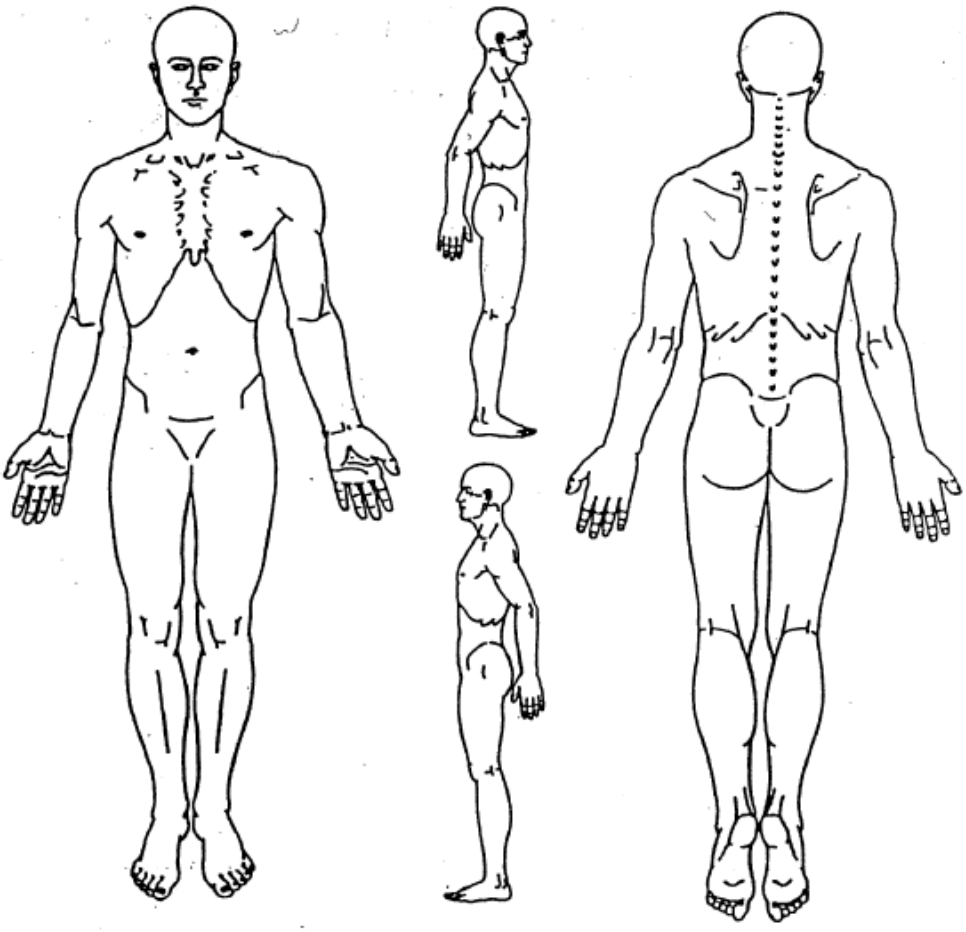
Occupation: _____ E-Mail:_____

Employer: _____ Referred By: _____

General Pain Disability Index

Use the letters to indicate the type and location of your sensations right now.

A (ache) B(burning) N(numbness) P(pins & needles) S(stabbing) O(other)



What is the main problem? When did it begin? How? _____

_____

Have you had this or a similar problem in the past? If Yes, please explain_____

_____

Does anything aggravate it? _____

Does anything make it better? _____

Does the complaint radiate/travel to other areas? _____

Rate the severity of the pain? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme)

How often does it occur? (never) 0 1 2 3 4 5 6 7 8 9 10 (constant)

Activities/movements difficult to perform: sit stand walk bend lay down (circle all that apply)

Have you received treatment for this elsewhere or being co-managed concurrently?

Massage Medical doctor Physiotherapy Chiropractor Other_____

Are you currently on any medications, herbs, vitamins, supplements, birth control? _____

_____

Do you have any allergies? _____

Name of your medical doctor? _____

PAST HISTORY

Have you ever had any of the following:

Describe	Date
Surgeries:	
Injuries:	
Auto Accidents:	
Hospitalizations:	
Major Illnesses:	

For existing patients currently being co-managed within Adjust Your Health, please initial here to give your consent for the chiropractor to copy your initial intake form & consult with the referring practitioner. _____.

LIFESTYLE

EXERCISE	**WORK**	**HABITS**	**STRESS LEVEL**
_____ None _____ Moderate _____ Daily _____ Heavily	_____ Sit _____ Stand _____ Light Labour _____ Heavy Labour	_____ Smoke(___packs/day) _____ Alcohol(_____drinks/wk) _____ Caffeine(_____cups/day)	_____ None _____ Moderate _____ High (Reason: _____)

Please check all that apply to current or previous health history. Although some of the conditions may seem unrelated to the purpose of your appointment, it is important that the chiropractor have a complete and clear history of your total health. This may affect your overall diagnosis, treatment plan & possibility of being accepted for care.

___ Allergy/shots
___ Anemia
___ Anorexia
___ Appendicitis
___ Asthma
___ Bleeding disorder
___ Bronchitis
___ Cataracts
___ Chemical dependency
___ Chicken pox
___ Diphtheria
___ Emphysema
___ Fractures
___ Glaucoma
___ Goiter
___ Gonorrhea
___ Gout
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herniated Disc
___ Herpes
___ High Cholesterol
___ Influenza
___ Kidney Disease
___ Liver Disease
___ Malaria
___ Measles
___ Mental Disorder
___ Miscarriage
___ Mononucleosis
___ Mumps
___ Osteoporosis
___ Pacemaker
___ Parkinson's Disease
___ Pinched nerve
___ Pleurisy
___ Pneumonia
___ Polio
___ Prostate Problems
___ Prosthesis
___ Psychiatric care
___ Rheumatoid Arthritis
___ Scarlet Fever
___ Small Pox
___ Stroke
___ Suicide attempt
___ Thyroid problems
___ Tonsillitis
___ Tuberculosis
___ Tumors/growths
___ Typhoid Fever
___ Ulcers
___ Vaginal infections
___ Whooping cough
Other:_____

FAMILY MEDICAL HISTORY

Do you or a family member have a history of the following? Please indicate which family member.

___ Alcoholism
___ Allergies
___ Arthritis
___ Asthma
___ Cancer
___ Cardiovascular Disease
___ Depression
___ Diabetes
___ Epilepsy
___ Genetic Disease
(_____)
___ Hyperactivity
___ High Blood Pressure
___ HIV
___ Learning Disability
___ Multiple Sclerosis
___ Schizophrenia
___ Seizures
___ Ulcers
___ Venereal Disease
Other:_____

REVIEW OF SYSTEMS

Please check all that apply to current or previous health history (especially in the last 6 months).

GENERAL

____Nervousness
____Irritability
____Depression
____Fatigue
____Sleep disturbances
____Weight changes
____Fever

HEAD

_____Headache (circle)
Entire head/Back of Head/ Temple/Forehead/Migraines
____Head trauma
____Dizziness
____Fainting
____Lighted headedness
____Memory loss

EYES

____Change in vision
____Glasses/contacts
____Blurry vision
____Double vision
____Flashes/spots
____Light sensitive

EARS

____Ringing
____Hearing loss
____Frequent infection
____Pain
____Buzzing
____Drainage

NOSE

____Nosebleeds
____Sinus problems

MOUTH/THROAT

____Jaw pain
____Change in taste
____Hoarseness
____Trouble swallowing
____Slurred speech

NECK

____Pain
____Stiffness
____Grinding/popping
____Muscle Spasm
____Swelling

CHEST

____Pain
____Shortness of breath
____Pain around ribs
____Cough

MIDBACK

_____Tired/weakness
____Muscle spasm
____Sharp pain with breathing

LOW BACK

_____Pain
____Muscle spasm
____Condition worsens with (circle)
Work/Lifting/Standing/Sitting/ Coughing/Sneezing/Lying down/ Rest/Activity

GASTROINTESTINAL

_____Heartburn
____Indigestion
____Gas
____Abdominal Pain
____Bloating
____Nausea/Vomiting
____Diarrhea
____Constipation
____Blood in Stool
____Difficulty in Bowel Control

GENITO-URINARY

_____Difficulty urinating
____Pain with urination
____Blood in urine
____Change (amt & frequency)
____Prostate changes/problems
____Intercourse problems

UPPER EXTREMITY

____Pain (circle)
Upper Arm/Forearms/ Hands/Fingers
_____Pins & Needles (circle)
Arms/Fingers
____Numbness
____Cold hands/fingers
____Swollen or sore joints
____Loss of strength

WOMEN ONLY

_____Irregular periods
____Menstrual cramps
____PMS
____Menstrual Migraines
____Hot flashes
____Menopause
____Lumps in breast
____Nipple discharge

LOWER EXTREMITY

_____Pain (circle)
Buttocks/hip joint
_____Pain travels (circle)
Down one leg/Down both
_____Cramping
_____Pins & Needles (circle)
Gluts/Feet/Toes
_____Numbness (circle)
Legs/Feet/Toes
_____Swollen Ankles
_____Painful toe joint
_____Painful knee joint

Informed Consent

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments/manipulation are required to advise patients that there may be some risks associated with such treatment. In particular you should note:

A) While rare, some patients have experienced rib factures, muscle strains, or ligament sprains following spinal adjustments/manipulation 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 have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments/manipulation although no scientific study has ever demonstrated such an injury is caused, or may be caused, by spinal adjustments/manipulation or 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

Chiropractic treatment, including spinal adjustment/manipulation, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall health. The risk of injuries or complication from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic and acupuncture treatment in general and my treatment in particular, including spinal adjustment/manipulation, as well as the contents of this Consent.

I consent to the chiropractic/acupuncture treatments offered or recommended to my by my chiropractor. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (please print) Signature of Patient (or Parent/Guardian)

_____ _____

Date (Day/Month/Year) Witness / Verification of Signature