Name: _____ Birthdate: _____ **CHIROPRACTIC SUPPLEMENT FORM**

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. _____.

Have you ever been to a chiropractor before? NO/YES (if yes, please indicate previous reason why & results)

_____

_____

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
___ Depressio
___ 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

NECK

____Pain
____Stiffness
____Grinding/popping
____Muscle Spasm
____Swelling

GENITO-URINARY

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

HEAD

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

CHEST

____Pain
____Shortness of breath
____Pain around ribs
____Cough

MIDBACK

____Tired/weakness
____Muscle spasm
____Sharp pain with breathing

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

EYES

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

LOW BACK

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

WOMEN ONLY

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

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

GASTROINTESTINAL

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

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

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 through 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.

_____
Name (Please Print)

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

_____ Date: _____ 20____
Signature of Chiropractor