

New Patient Intake Form – Chiropractic Medicine

Patient Information

Name: Mr. Mrs. Ms. Miss. Dr.	First Namo C	urname
Address:		
Street Age: Date of Birth:	City/Town Marital Status:	Postal code
Phone #: Home ()		
wor <u>k.</u>		
Can we leave a message? If yes, please specify at which local	ation Home Work L	Cell
Occupation: E	Employer's Name:	
Emergency Contact:		
Emergency Contact Phone #:		
Physicians Name:	Phone #: <u>(</u>)	
Address:		
Street	City/Town	Postal code
Extended Health Care Carrier (if Applicable):		
How did you hear about this office?		
	If Yes, by whom?	
Health Information		
Have you had previous: Chiropractic Care Ph	ysiotherapy	☐ Massage Therapy
If yes, please specify the reason for care:		
Please specify the reason for today's visit:		
Have you had this pain before? Yes No If, yes v	vhen:	
How are the symptoms changing? Gotten worse	☐Stayed the same ☐ Gotten	better
Is your Injury a result of: Motor Vehicle Accident	☐Work Related ☐Sport Re	elated
If Other Please Specify:		

or dis	uctions: Please scomfort on th the appropria	e adjace	ent diagr	• •	R		27	L	及公	L			>	R
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On a Scar	e of 0 to 10, pl	ease cir	cie tile a	verage inte	ensity of	your symp	toms.							
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Medications

Medications					
Are you currently taking any me	dications (prescript	ion or over th	e counter)? If	yes, please note:	
1- Medication			Dos	sage	
2- Medication				sage	
3- Medication			Dos	sage	
4- Medication			Dos	sage	
5- Medication			Dos	sage	
Family History					
Please check if any one of your f	amily members hav	e or have had	l any of the fol	llowing, and if so how are y	ou related?
☐ Cancer	Mother	Father	Sibling	Other (specify)	
☐ Heart Disease	Mother	Father	Sibling	Other (specify)	
☐ Stroke	Mother	Father	Sibling	Other (specify)	
☐ Diabetes	Mother	Father	Sibling	Other (specify)	
☐ High Cholesterol	Mother	Father	Sibling	Other (specify)	
☐ Hypertension	Mother	Fa	ther	Sibling	Other (specify)
☐ Other, Please specify					
					_
Social History					
Do you smoke?	No If yes,	, how many pa	acks/day?	For how long? _	
Do you consume alcohol?	J _{Yes} □ _{No}	If yes, how n	nany drinks/w	reek?	
Do you exercise?	No If yes, h	now many tim	es/week?		
Terms and Policies					
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We require 24 hours notice , if a accommodate other patients/cl be subject to the full service fee	ients. All patients/o				
I have read and understand this	policy.				
I have stated all conditions that Centre of any changes to my sta		his information	on is true and	accurate. I will inform Chire	omedics Health
Print Name					
Print Name					

Consent to Chiropractic Treatment:

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 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.

Witness of Signature
Name:(please print)