Blackfalds Chiropractic Centre
5007 Broadway Ave.
P.O. Box 1510
Blackfalds, AB. T0M 0J0
Phone: 403-885-5808

Adult Health History

Date:_____

Patient's Name:_____ Alberta Healthcare #:_____ Sex: ☐ M ☐ F

Mailing Address:_____ City:_____ Province:_____ Postal Code: _____

Home#: _____ Work#: _____ Cell#: _____

Email:_____

Would you like reminders of your upcoming appointments by: ☐ Emailed ☐ Text Would you like Emailed Receipts? ☐ No ☐ Yes

Date Of Birth: D/____ M/____ Y:_____ Age: _____ Married: ☐ Single: ☐ How Many Children: ____ Occupation:_____

Emergency Contact:_____ Phone#:_____

Who may we thank for referring you to our office?_____ Is this W.C.B? ☐ No ☐ Yes

1. What is the purpose of this appointment? ☐ Wellness ☐ Automobile Accident Other_____
2. What area(s)? ☐ Neck ☐ Shoulders ☐ Mid-back ☐ Low-back ☐ Hips Other_____
3. Where? ☐ Left ☐ Middle ☐ Right ☐ Front ☐ Back Other_____ Date symptoms appeared_____
4. How long ago did symptoms first start?: ☐ Hours ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ Chronic on /off
5. Rate the severity of your symptoms: ☐ Mild ☐ Moderate ☐ Severe
6. Did they start: ☐ Gradual or ☐ Suddenly
7. Describe your symptoms: ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Stabbing ☐ Deep ☐ Shooting Other:_____
8. Do your symptoms: ☐ Come and Go or ☐ Stay Constant
9. Do you experience ☐ tingling or ☐ numbness in:
   ☐ Shoulders ☐ Hips ☐ Arms ☐ Knees ☐ Hands ☐ Feet ☐ Legs ☐ Elbows
10. Are your symptoms worse in the: ☐ Morning ☐ Evening ☐ No change
11. What aggravates your condition: ☐ Stress ☐ Activity ☐ Lifting ☐ Standing ☐ Sitting ☐ Working ☐ Sleeping Other _____
12. What Relieves your Symptoms:
    ☐ Rest ☐ Ice ☐ Heat ☐ Lying ☐ Adjustment ☐ Massage ☐ Standing ☐ Sitting ☐ Medication ☐ Nothing
13. Is your condition interfering with your: ☐ Quality of life ☐ Work ☐ Sleep Other
14. Have you had this problem before?: ☐ No ☐ Yes_____
15. Other Doctors you have seen for this condition: ☐ MD ☐ Neurologist ☐ Orthopedic Surgeon ☐ Chiropractor Other _____

Dr. Name_____ Diagnosis_____ Were X-rays Taken? ☐ No ☐ Yes Treatment: _____

Physiotherapy/Muscle Therapy? ☐ No ☐ Yes Results, did it help? ☐ No ☐ Yes

16. Date of last Physical Exam:_____ Purpose?_____ **Female** are you pregnant? ☐ No ☐ Yes ☐ Unsure
17. What medications are you taking, including over the counter?_____
18. Have you ever:

	No	Yes	Briefly Explain:
Broken bones	☐	☐	_____
Been hospitalized	☐	☐	_____
Been in an auto accident	☐	☐	_____
Had sprains/strains	☐	☐	_____
Been Struck unconscious	☐	☐	_____
Had Surgery	☐	☐	_____

19. Have you ever been under Chiropractic Care? ☐ N ☐ Y Reason?_____

Chiropractor's Name:_____ Date of last visit:_____

20. Are you suffering from any of the following:

☐ Allergies/Hay fever	☐ Low back pain	☐ Tuberculosis	☐ Itching
☐ Dizziness	☐ Neck pain/stiffness	☐ Pleurisy	☐ Psoriasis/Eczema
☐ Fatigue	☐ Poor Posture	☐ Bruise easily	☐ Bedwetting
☐ Headaches/Migraines	☐ Sciatica	☐ Nose bleeds	☐ Frequent Urination
☐ Loss of Sleep	☐ Spinal Curvatures	☐ Sinus Infection	☐ Kidney Infection/stone
☐ Nervousness/Depression	☐ Colon Trouble	☐ Heart Disease	☐ Heavy Menstrual
☐ Ulcers	☐ Swollen Joints/Ankles	☐ High/Low blood pressure	☐ Prostate Trouble
☐ Numbness	☐ Menstrual Cramps	☐ Pain over Heart	☐ Irregular Cycle
☐ Arthritis	☐ Rapid/slow Heartbeat	☐ Poor Circulation	☐ Hot Flashes
☐ Asthma	☐ Stroke	☐ Difficulty Breathing	☐ Difficult Digestion
☐ Bursitis	☐ Hemorrhoids	☐ Venereal Disease	☐ Lumps in Breasts
☐ Foot Trouble	☐ Nausea	☐ Anemia	☐ Cancer
☐ Colds / Flu	☐ Enlarged Thyroid	☐ Chest Pain	☐ Polio
☐ Deafness	☐ Eye pain/bad vision	☐ Alcoholism	☐ Aids/HIV Positive
☐ Ear Noise	☐ Hypoglycemia	☐ Diabetes	☐ Fibromyalgia
☐ Chronic Fatigue Syndrome	☐ Other:_____		

21. Do you have any family history of illness?_____

22. Your level of stress at: **Home:** ☐ High ☐ Medium ☐ Low **Work/School:** ☐ High ☐ Medium ☐ Low

23. Are you wearing: ☐ Heel lifts ☐ Prescribed Orthotics ☐ Arch Support

24. Are you taking Nutritional Supplements: ☐ No ☐ Yes _____

25.Describe Your Habits:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐

PAYMENT IS EXPECTED AT THE TIME OF VIST!

Name of person responsible for Payment_____

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and Payable.

I understand that chiropractic does not treat the disease or symptoms but uses them to ascertain where the specific adjustment(s) is/are needed. Chiropractic only attempts to adjust vertebrae, restoring the nerve impulse to the involved tissue, thus allowing the body its best chance of healing itself

Patient / Guardian Signature: _____ **Date:**_____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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

Please turn over

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: _____
Signature of patient (or legal guardian)

_____ Date: _____
Signature of Chiropractor