

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



### Child Health History

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Alberta Healthcare #: \_\_\_\_\_ Sex: M F

Date Of Birth: D/\_\_\_\_M/\_\_\_\_Y/\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_ Would you like Emailed? Receipts No Yes

Would you like reminders of your upcoming appointments by: E mailed Text

Mothers Name: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Fathers Name: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

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 Adjustment Massage Standing Sitting Medication Nothing
13. Is your condition interfering with your: Quality of life School 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 \_\_\_\_\_
- Physiotherapy/Muscle Therapy? No Treatment: Yes Results, did it help? No Yes
16. Date of last medical appointment: \_\_\_\_\_ Purpose? \_\_\_\_\_
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?    Y        N    Reason? \_\_\_\_\_

Chiropractor's Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

20. Are you suffering from any of the following:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Allergies/Hay fever    | <input type="checkbox"/> Low back pain         | <input type="checkbox"/> Nausea                  | <input type="checkbox"/> Itching                |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Neck pain/stiffness   | <input type="checkbox"/> Foot Trouble            | <input type="checkbox"/> Psoriasis/Eczema       |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Poor Posture          | <input type="checkbox"/> Bruise easily           | <input type="checkbox"/> Bedwetting             |
| <input type="checkbox"/> Headaches/Migraines    | <input type="checkbox"/> Sciatica              | <input type="checkbox"/> Nose bleeds             | <input type="checkbox"/> Frequent Urination     |
| <input type="checkbox"/> Loss of Sleep          | <input type="checkbox"/> Spinal Curvatures     | <input type="checkbox"/> Sinus Infection         | <input type="checkbox"/> Kidney Infection/stone |
| <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Swollen Joints/Ankles | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Menstrual issues      | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Numbness               | <input type="checkbox"/> Rapid/slow Heartbeat  | <input type="checkbox"/> Pain over Heart         | <input type="checkbox"/> Deafness               |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Colds / Flu           | <input type="checkbox"/> Poor Circulation        | <input type="checkbox"/> Chest Pain             |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Eye pain/bad vision    |
| <input type="checkbox"/> Bursitis               | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Other: _____            |   |

21. Do you have any family history of illness? \_\_\_\_\_

22. Your level of stress at: **Home:**    High    Medium    Low    **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

- |             |                          |                          |                          |                          |
|-------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Exercise    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Soft Drinks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Water       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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

**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

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

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient (or legal guardian)

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Chiropractor