

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City, Province

Postal Code

Telephone Home: (____) _____ Work: (____) _____

E-mail: _____ Cell: (____) _____

Your email address will only be used as a method of contacting you if necessary.

Please check this box if you would like to receive a monthly newsletter:

What is the best time and location to reach you? _____

Sex: _____ Age: _____ Date of Birth: _____ (DD/MM/YY)

Occupation: _____ Employer's Name: _____

Emergency Contact: _____

Home: (____) _____ Business: (____) _____

How did you find out about our clinic? _____

Is there a specific person we may thank for your visit? _____

If you have an injury to be covered by the Workplace Safety and Insurance Board (WSIB) or automobile insurance, please inform the receptionist.

Consent to Consultation and Examination

I consent to consultation and examination to determine if chiropractic treatment would be beneficial to me. I understand that the examination may cause some tenderness and/or discomfort, but that it will be short-lived.

Name (print): _____ Signature: _____ Date: _____



Dr. Jennifer Heick & **Dr. Rebecca Blackburn**
550 Parkside Drive, Unit A4, Waterloo ON N2L 5V4
519-746-3838 | wncm@rogers.com | www.wncm.ca

Patient's Name: _____

Date of Birth: _____ (DD/MM/YY)

Current Condition

If you have a specific condition please complete these questions, otherwise go on to the next section of this form.

What is your major complaint? _____

How long have you had this condition? _____

Did it begin:
 Suddenly
 Gradually

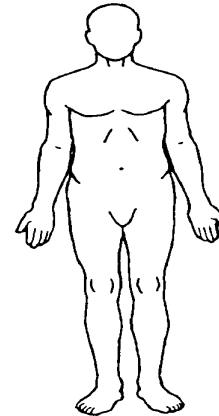
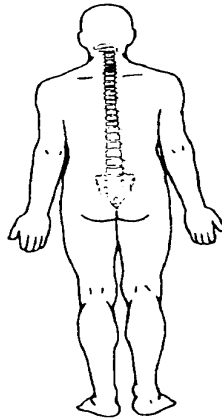
Is the condition:
 Getting worse Consistent
 Getting better Comes and goes

Is there pain:
 At night
 On coughing or sneezing

Describe if the pain travels: _____

Please mark your area(s) of concern using the symbols that you feel best describe what you are experiencing:

- Numbness -----
- Burning #####
- Stabbing ++++++
- Pins & Needles :::::
- Aching *****
- Stiff/Tight // ////



Place an "X" on the line to indicate the amount of pain/discomfort associated with your condition:

No Pain [0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10] Worst Pain Ever

What activities or positions cause aggravation? _____

What activities or positions provide relief? _____

Please describe any past episodes: _____

If there was an injury or event that lead up to this condition, please describe: _____

If any health practitioner has previously treated you for this condition, please specify:

Location: _____ When: _____ Nature of Treatment: _____

May we follow up? (Please circle) Yes No

Has anyone else in your family had a similar complaint? _____

Other areas of concern: _____

Previous injuries: _____



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Personal Health History

Please indicate any current or past conditions:

- | | | |
|--|--|--|
| <input type="checkbox"/> neck pain/stiffness | <input type="checkbox"/> thyroid dysfunction | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> headaches | <input type="checkbox"/> tremors | <input type="checkbox"/> cancer |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> weakness | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> pain in arms or hands | <input type="checkbox"/> fainting | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> dizziness/vertigo | <input type="checkbox"/> stroke |
| <input type="checkbox"/> pain in legs or feet/sciatica | <input type="checkbox"/> earaches/ear discharge | <input type="checkbox"/> hardening of arteries |
| <input type="checkbox"/> spinal curvature | <input type="checkbox"/> ear ringing/buzzing | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> swollen joints | <input type="checkbox"/> deafness | <input type="checkbox"/> poor circulation |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> double/blurred vision | <input type="checkbox"/> rapid/slow heart beat |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> near or far sightedness | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> allergies/food sensitivities | <input type="checkbox"/> enlarged glands | <input type="checkbox"/> bed wetting |
| <input type="checkbox"/> digestion dysfunction | <input type="checkbox"/> loss of weight | <input type="checkbox"/> painful urination |
| <input type="checkbox"/> gall bladder problems | <input type="checkbox"/> depression/anxiety | <input type="checkbox"/> prostate trouble |
| <input type="checkbox"/> jaundice/liver problems | <input type="checkbox"/> asthma | <input type="checkbox"/> cramps/painful periods |
| <input type="checkbox"/> hernia | <input type="checkbox"/> sinus infection | <input type="checkbox"/> irregular cycles |
| <input type="checkbox"/> autoimmune disorder | <input type="checkbox"/> breathing dysfunction | <input type="checkbox"/> menopausal |
| <input type="checkbox"/> ankylosing spondylitis | <input type="checkbox"/> bruise easily | <input type="checkbox"/> pregnant |
| <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> varicose veins | |
| <input type="checkbox"/> other _____ | | |

General Practitioner (MD): _____ Phone: _____

How long since your last full physical examination with a medical doctor? _____

May we follow up with your medical doctor regarding your care? Yes: No:

Describe any previous chiropractic care (if applicable):

Location: _____ When: _____

Have you had any X-ray/MRI/CAT scan/bone scan taken in the last five years (other than dental)?

- Yes What areas of the body? _____
- No

If you have ever been hospitalized, please specify:

Location: _____ When: _____

Nature of Treatment: _____

What medication have you taken in the last 3 months?

- | | | |
|--|--|--|
| <input type="checkbox"/> Muscle Relaxant | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Pain Killers | <input type="checkbox"/> Insulin | <input type="checkbox"/> Natural Therapies |
| <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Birth Control | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sedative | <input type="checkbox"/> Antacids | _____ |

Have you had an automobile accident?

- in the past 6 months
- in the past year
- in the past 5 years
- never

Describe any other accidents or falls that involved injury: _____

If you have ever been told you have a congenital malformation of the vertebral column, please specify:

Do you have a pacemaker or IUD? _____

How long has it been since you felt really good? _____



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Family History

Has anyone in your family had any of the following conditions?

- Autoimmune disorder _____
- Ankylosing Spondylitis _____
- Arthritis/Rheumatism _____
- Multiple Sclerosis _____
- Muscular Dystrophy _____
- Back Pain _____

Relationship

- Cardiac/Heart Problems _____
- High Blood Pressure _____
- Low Blood Pressure _____
- Stroke _____
- Diabetes (type?) _____
- Cancer (type?) _____

Relationship

Lifestyle

Please describe your use of:

- Tobacco: _____ Packs per week
 - Alcohol: _____ Drinks per week
 - Tea/Coffee: _____ Cups per week
 - Exercise: _____ Times per week
 - Sleep: _____ Hours per night
- Type of bed: _____
- Sleep on back
 - Sleep on left side
 - Sleep on right side
 - Sleep on stomach
- Age of your pillow: _____
- Flat pillow
 - Contoured pillow

Describe your physical activities/exercises. Please include the frequency, distances, times, etc:

Please describe your diet, eating patterns and fluid intake:

Place an "X" on the line to indicate the amount of stress associated with your current lifestyle:

No Stress [0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10] Worst Stress Ever

Please describe what you do during your work day (standing, sitting at computer, driving, lifting, hammering, etc):

- If at a desk, is your computer: in front of you off to the side
- Is your keyboard: on the desk on a keyboard tray
- Which hand do you use your mouse with? left right
- Do you: sit back in your chair lean forward a combination of both

- Do you often wear shoe inserts? Yes No
- If yes, are they: Heel lifts Off the shelf, store-bought insoles/orthotics Custom orthotics
- How old are they? _____ When were they last checked? _____

Chiropractic is beneficial for restoring, maintaining and improving health and wellness. Please indicate the goals you wish to achieve by visiting this clinic:

- Pain relief from your current health problem
- Maintaining health
- Improving of health



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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

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. 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 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 other 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.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____
(please print)

Name: _____
(please print)



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