

# REASSESSMENT FORM

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

***Please update any of the information below that may have changed since your last visit.  
If you have any questions, please feel free to ask the receptionist.***

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

Telephone Home: (\_\_\_\_) \_\_\_\_\_ Business: (\_\_\_\_) \_\_\_\_\_

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: (\_\_\_\_) \_\_\_\_\_

***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**   
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Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (DD/MM/YY)

**Current Condition**

*If you have a specific condition, please complete the 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
- Getting better
- Consistent
- Comes and goes

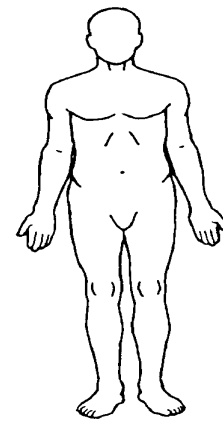
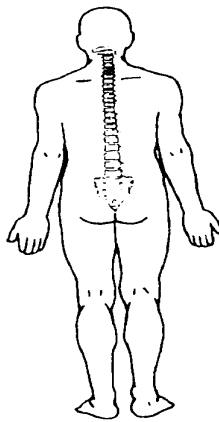
Is there pain:

- 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 \_\_\_\_\_

Can 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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## 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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