CONFIDENTIAL PATIENT INFORMATION

Name:	Date:
Street Address:	
	Postal Code:
Telephone Home: ()	Work: ()
Mobile: ()	Other Phone: ()
What is the best time and phone number to re-	each you?
E-mail:	
E-mail reminders are sent out 2 days before	your appointment. You may opt out if you wish.
Date of Birth:	(DD/MM/YY) Age: Sex:
Occupation:	Employer's Name:
Marital Status:	Children/Ages:
Emergency Contact:	
Home: ()	Other: ()
Family Doctor (MD):	Phone:
How long since your last full physica	l examination with a medical doctor?
May we follow up with your medical	doctor regarding your care?
How did you find out about our clinic?	
Is there a specific person we may thank for y	our visit?

I understand and agree that: a) fees are payable at the time of service, and b) WNCM is authorized to leave a message at the numbers above, or specific arrangements have been made. **Please initial**:_____

NOTES:

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

Office Use Only:

Informed	Consent	Info	
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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? ______

Did it begin:	Is the condition:		Is there pain:
□ Suddenly	□ Getting worse	□ Consistent	Î At night
Gradually	□ Getting better	□ Comes and goes	\Box 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			SR		Sol	
Burning	####				(MA)	
Stabbing	++++++				$(\lambda - \lambda)$	
Pins & Needles	:::::	4	and the second		W Y No	
Aching	* * * *		}{{-{			
Stiff / Tight	//////		LIL			
Place an "X'	" on the line to	o indicate the amour	nt of pain/discomfc	ort associated with	your condition:	
		No Pain [01	23456	5789	10] Worst Pain Ever	
How long ha	as this been a j	problem?				
If there was	an injury or ev	vent that led up to th	is condition, pleas	e describe:		
Which activi	ities or positio	ons cause aggravatio	n?			
Which activi	ities or positio	ons provide relief? _				
Please descr	ibe any past e	pisodes:				
If any health	n practitioner h	nas previously treate	d you for this cond	lition, please spec	ify:	
Locatio	on:	When:		Nature of Treatm	nent:	
May we	e follow up?	□ Yes □ No				
Has anyone	else in your fa	mily had a similar c	complaint?			
Have you ha	ad an automob	ile accident? 🗖 Ye	es 🗆 No If yes	, when?:		
Describe any	y other accider	nts or falls that invol	lved injury:			
If you have e	ever been told	you have a congeni	tal malformation o	f the vertebral col	lumn, please specify:	

Other areas of concern:



No Yes Which areas of the body? Please indicate any current conditions with a Y or past conditions with an X , even if they seem unrelated to your present condition:	Name:	Date of Birth:	(DD/MM/YY)
Describe any previous chiropractic care (if applicable): Location:	Personal Health History		
Type of Treatment:	Describe any previous chiropractic care (if a		
Type of Treatment:	Location:	When:	
No Yes Which areas of the body? Please indicate any current conditions with a Y or past conditions with an X , even if they seem unrelated to your present condition:	Type of Treatment:	Outcome	2:
□ headaches □ thyroid dysfunction □ chest pain □ pain in arms or hands □ tremors □ heart disease □ low hack pain □ weakness □ hardening of arteries □ disc bulge/herniation □ disc bulge			
□ nck pain/stiffness □ multiple sclerosis □ diabetes (type l/l) □ headaches □ typroid dysfunction □ cancer □ pain in arms or hands □ tremors □ heat disease □ pain in ges or feet/sciatica □ fainting □ heat disease □ pain in legs or feet/sciatica □ fainting □ heat disease □ pain in legs or feet/sciatica □ fainting □ hardening of arteries □ disc bulge/hemiation □ dizziness/vertigo □ high/ow bhodo pressu □ stenosis □ ear arches/ear discharge □ poor circulation □ synal curvature □ ear arches/ear discharge □ poor circulation □ synal curvature □ ear arches/ear discharge □ poor circulation □ synal curvature □ ear arches/ear discharge □ poor circulation □ synal curvature □ ear arches/ear discharge □ poor circulation □ synal curvature □ ear arches/ear discharge □ poor circulation □ bynal curvature □ ear arches/ear discharge □ poor circulation □ synal curvature □ car arches/ear discharge □ poor circulation □ athritis □ dots of weight □ cramps/painful priodis □ diader problems		a \checkmark or past conditions with an X , even if the	ey seem unrelated to your present
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autoimmune disorder bruise easily psoriasis ankylosing spondylitis varicose veins other			
ankylosing spondylitis varicose veins			
□ other			□ psoriasis
Do you have a pacemaker or IUD?			
If you have ever been hospitalized, please specify: Location:			
Location:	Do you have a pacemaker or IUD?		
Nature of Treatment:		•	
Please list prescription medications, natural remedies and vitamins that you've taken in the last 3 months: Medication/Over the Counter Supplement Reason for use? /Vitamin	Nature of Treatment:	when	
Medication/Over the Counter Supplement Reason for use? /Vitamin			
/Vitamin			he last 3 months:
If yes, are they: Heel lifts Off the shelf, store-bought insoles/orthotics Custom orthotics How old are they? When were they last checked?		Reason for use?	
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	now long has it been since you have felt real	ny good?	

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Name:				Date of Birth:		(DD/MM/YY)
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Lifestyle			_			
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 Alcohol: Tea/Coffe Exercise: Sleep: 		Drinks per week Cups per week Times per week	□ Sleep □ Sleep □ Sleep			Flat pillow Contoured pillow
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CONSENT TO CHIROPRACTIC TREATMENT

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.

<u>Risks</u>

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:

- <u>Temporary worsening of symptoms</u> Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- <u>Skin irritation or burn</u> 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.
- <u>Sprain or strain</u> 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.
- **<u>Rib fracture</u>** 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.
- <u>Injury or aggravation of a disc</u> 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 (Please Print)		
	Date:	20
Signature of patient (or legal guardian)		
	Date:	20
Signature of chiropractor		



Dr. Jennifer Heick □ Dr. Rebecca Blackburn □ Dr. Jonathan Oosterhof □ 550 Parkside Drive, Unit A4, Waterloo ON N2L 5V4 519-746-3838 | wncm@rogers.com | www.wncm.ca Page 6 of 6