File #: J_____

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: _____

Street Address: _____

City: _____ Postal Code: _____

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

Mobile: (_____) _____ Other Phone: (_____) _____

What is the best time and phone number to reach 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 physical examination with a medical doctor? _____

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

How did you find out about our clinic? _____

Is there a specific person we may thank for your 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**:_____

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**
Chiro		
GT		
Laser		
Acu		

NOTES:

WATERLOO NORTH Chiropractic & Massage

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

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.

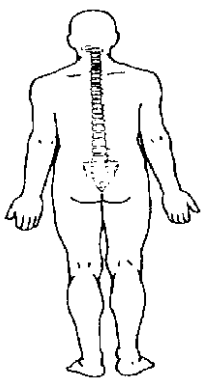
What is your major complaint? _____

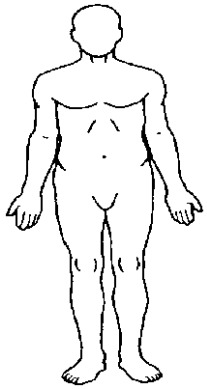
Did it begin:	Is the condition:		Is there pain:
☐ Suddenly	☐ Getting worse	☐ Consistent	☐ At night
☐ Gradually	☐ Getting better	☐ Comes and goes	☐ On coughing or sneezing

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

How long has this been a problem? _____

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

_____

Which activities or positions cause aggravation? _____

Which activities or positions provide relief? _____

Please describe any past episodes: _____

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

Location: _____ When: _____ Nature of Treatment: _____

May we follow up? ☐ Yes ☐ No

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

Have you had an automobile accident? ☐ Yes ☐ No If yes, when?: _____

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:

_____

Other areas of concern: _____

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

Personal Health History

Describe any previous chiropractic care (if applicable):

Location: _____ When: _____

Type of Treatment: _____ Outcome: _____

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

☐ No ☐ Yes Which areas of the body? _____

Please indicate any **current** conditions with a ✓ or **past** conditions with an **X**, even if they seem unrelated to your present condition:

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

Do you have a pacemaker or IUD? _____

If you have ever been hospitalized, please specify:

Location: _____ When: _____

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 /Vitamin	Reason for use?

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? _____

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

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

Family History

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

	Relationship		*Relationship*
☐ Autoimmune disorder	_____	☐ Cardiac/Heart Problems	_____
☐ Ankylosing Spondylitis	_____	☐ High Blood Pressure	_____
☐ Arthritis/Rheumatism	_____	☐ Low Blood Pressure	_____
☐ Multiple Sclerosis	_____	☐ Stroke	_____
☐ Muscular Dystrophy	_____	☐ Diabetes (type?)	_____
☐ Back Pain	_____	☐ Cancer (type?)	_____

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, driving, lifting, hammering, etc):

_____

_____

If at a desk,

Are your computer monitor(s): ☐ in front of you ☐ off to the side (Right/Left)

Is your keyboard: ☐ on the desk ☐ on a keyboard tray

With which hand do you use your mouse/track pad? ☐ left ☐ right

Do you: ☐ sit back in your chair ☐ lean forward ☐ sit on the edge of the seat ☐ a combination ☐ stand

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 health

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:_____

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.

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 (Please Print)

_____ Date: _____ 20____

Signature of patient (or legal guardian)

_____ Date: _____20____

Signature of chiropractor