FOR OFFICE USE ONLY:

Patient ID# _____

Date _____

Practitioner _____

Chiropractic Wellness Clinic

CONFIDENTIAL PATIENT INFORMATION

CHIROPRACTIC , ACUPUNCTURE & MASSAGE #210, 240 Midpark Way S.E., Calgary, AB T2X 1N4 **Tel. (403) 254-5774**

Completion of this confidential form is required by all Chiropractic Wellness Clinic patients on their first visit so the practitioners providing your care are accurately informed. We also ask that you keep us up-to-date with this information as it changes, as this is part of your permanent record.

It is our clinic policy to keep all of our records completely confidential. No copy of your file shall be released unless the request is accompanied with your signed consent. All of your original records will remain at the Chiropractic Wellness Clinic for up to seven years after which they may be shredded and destroyed.

Name (Last)_____ (First)_____ (Middle) _____ Male / Female

Address _____ City _____ Province _____ Postal Code _____

Alberta Healthcare # __ __ __ __ __ - __ __ __ __ Marital Status Single Married Divorced Widow(er) Common Law

D.O.B. Day ____ Mo____ Yr____ Home Tel. (_____)_____ Work Tel.(____)_____ Mobile (____)_____

Spouse Name_____ Number of Children ____ Names & Ages _____

Emergency Contact _____ Emergency Tel. (____)_____ Relationship_____

How did you first hear of our wellness clinic? _____ Did anyone refer you? Y N Who?_____

E-mail _____ I would like to receive newsletters and other wellness info via email Y N

Employer _____ Occupation _____ Number of hours you work per week _____

Circle your activities at work: Heavy Labour Light Labour Mostly Sitting Mostly Standing Walking/Moving Driving Computer

Other _____

Rate Your Stress Level (Mild / Moderate / Severe) At Work_____ At Home _____ Other:_____

What do you do to manage stress? _____

Insurance Company _____ $ Chiropractic _____ $ Orthotics _____ $ Massage_____

Have you ever been treated by a Chiropractic Doctor before?

Y N CHIROPRACTOR:_____

Tel. _____ Last Appt _____

X-rays taken? Y / N When? _____

Results: Excellent Good Fair Poor

Age when you first experienced spinal problems: _____

MEDICAL DOCTOR: _____

Tel. _____ Last Appt _____

Clinic Name/Location: _____

We encourage a team approach to wellness care. Do you give us permission to contact your MD regarding your appointments at our office and your health concerns & progress? Yes / No

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What is your current health concern or complaint? _____

When did you first seek treatment for this problem? D___ Mo___ Yr___ Have you seen another doctor for this condition? Y N

Who? _____ When? _____ How long? _____

Who? _____ When? _____ How long? _____

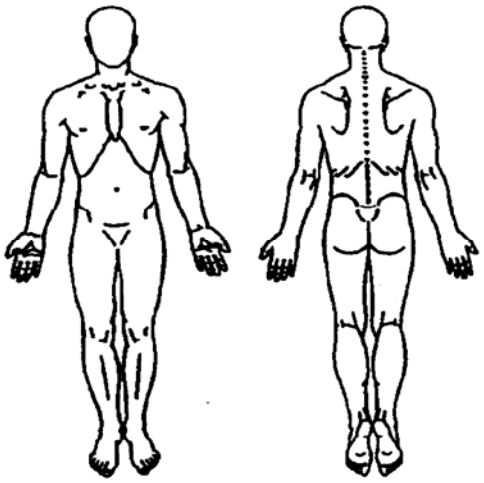
Who? _____ When? _____ How long? _____

How many days within the past year have you suffered with this condition? _____ How long has this episode lasted?_____

Is your condition accident related? Y N If so was this accident related to: Work ? Y N Auto? Y N Other? _____

Draw in you face. Show area(s) of pain or unusual feeling by marking these areas on this body using the appropriate symbols below.
Mark areas of radiation. Include all affected areas.

Pins & Needles	○○○	Burninig	x x x
Stabbing	////	Aching	✡✡✡
Numbness	●●●	Other_____	# # #



Rate your pain relating to your current condition using the following scale:

(0 = No Pain through 10 = Worst pain)	1	2	3	4	5	6	7	8	9	10
Current Pain Intensity	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Average Pain Intensity	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Worst Pain Intensity	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Have you ever suffered from:

Lower Back Pain:	Y ❑ N ❑	Pinched Nerves:	Y ❑ N ❑	Seizures:	Y ❑ N ❑	Allergies:	Y ❑ N ❑
Midback Pain:	Y ❑ N ❑	Chest Pain:	Y ❑ N ❑	Aneurysm:	Y ❑ N ❑	Polio:	Y ❑ N ❑
Neck Pain:	Y ❑ N ❑	Heart Trouble:	Y ❑ N ❑	Anxiety:	Y ❑ N ❑	Strokes:	Y ❑ N ❑
Headaches:	Y ❑ N ❑	Anemia:	Y ❑ N ❑	Diabetes:	Y ❑ N ❑	Hepatitis:	Y ❑ N ❑
Sinus Problems:	Y ❑ N ❑	Tuberculosis:	Y ❑ N ❑	Fatigue:	Y ❑ N ❑	HIV:	Y ❑ N ❑
Osteoporosis:	Y ❑ N ❑	Dizziness:	Y ❑ N ❑	Cancer:	Y ❑ N ❑	Pneumonia:	Y ❑ N ❑
Sleeping Difficulty:	Y ❑ N ❑	Respiratory Problems:	Y ❑ N ❑	Asthma:	Y ❑ N ❑	Arthritis:	Y ❑ N ❑
Ear Infections:	Y ❑ N ❑	Rheumatic Fever :	Y ❑ N ❑	Chicken Pox :	Y ❑ N ❑	Typhoid Fever:	Y ❑ N ❑
Tubes in Ears:	Y ❑ N ❑	Whooping Cough:	Y ❑ N ❑	Scarlet Fever:	Y ❑ N ❑	Measles:	Y ❑ N ❑
Chronic Illness:	Y ❑ N ❑	Mumps:	Y ❑ N ❑	Diphtheria:	Y ❑ N ❑	_____:	Y ❑ N ❑

List any major falls and accidents since childhood (Include dates): _____

_____

List all Surgeries & Operations (Include dates): _____

_____

List all Surgeries recommended but not performed:_____

List ALL Medications you are currently taking include any over the counter drugs:_____

_____

List the main side effects of your medications:_____

_____

List any Vitamins & Minerals you take:_____

_____

Have you previously been hospitalized? Y N List When: _____

List any family health conditions & problems: _____

_____

Have you ever been knocked unconscious? Y N If so, when & for how long? _____

Have you been treated for any other health condition in the past year? Y N If so, please list: _____

_____

Do you smoke? Y N If so, how many cigarettes/packs per day? _____

Do you drink? Y N If so, how much? Light Moderate Heavy

Please circle "N" if you have any of the following symptoms NOW & circle "P" if you had the symptom in the PAST.

N P	Lower Back Pain	N P	Hay Fever	N P	Confusion	N P	Fainting
N P	Neck Pain	N P	Hoarseness	N P	Nervousness	N P	Poor Apetite
N P	Midback Pain	N P	Jaw Pain	N P	Rapid Heart Rate	N P	Ear Aches
N P	Shoulder Pain	N P	Clicking in Jaw	N P	Slow Heart Rate	N P	Ear Noises
N P	Headaches	N P	Grinding Teeth	N P	Low Blood Pressure	N P	Balance Problems
N P	Leg Pain	N P	Swollen Glands	N P	High Blood Pressure	N P	Swollen Joints
N P	Elbow & Hand Pain	N P	Swallowing Pain	N P	Poor Circulation	N P	Paralysis
N P	Tingling in hands	N P	Lump in Throat	N P	Frequent Urination	N P	Muscle Aches
N P	Tingling in legs	N P	Heartburn	N P	Painful Urination	N P	Nasal Obstruction
N P	Cholesterol Problems	N P	Indigestion	N P	Hemmorhoids	N P	Crossed Eyes
N P	Breathing Difficulties	N P	Gas/Bloating	N P	Bladder Fullness	N P	Eye Pain
N P	Forgetfullness	N P	Excessive Thirst	N P	Bladder Infections	N P	Blurred Vision
N P	Foot Trouble	N P	Nausea	N P	Decreased Sex Drive	N P	Fever
N P	Ankle Pain	N P	Sweating	N P	Painful Intercourse	N P	Hay Fever
N P	Circulation Problems	N P	Voice Problems	N P	Impotence	N P	Allergies
N P	Knee Pain	N P	Choking	N P	Abdominal Pain	N P	Chest Pressure
N P	Menstrual Irregularities	N P	Vomiting	N P	Upset Stomach	N P	Irritability
N P	Sinus Pain/Congestion	N P	Sore Throat	N P	Persistent Coughing	N P	Fatigue
N P	Loss of Bowel Control	N P	Clammy Hands	N P	Recurrent Infections	N P	Walking Problems
N P	Loss of Bladder Condrol	N P	Varicose Veins	N P	Sweats	N P	Chest Pressure
N P	Constipation	N P	Swollen Ankles	N P	Intestingal Worms	N P	Seizures
N P	Diarrhea	N P	Liver Trouble	N P	Gall Bladder Trouble	N P	Skin Rashes
N P	Snoring Problems	N P	Bedwetting	N P	_____	N P	_____

For Our Women Patients:
Last Menstrual Date:_____ Are you Pregnant? Y N If yes, when is your due date?_____
Are you menopausal? Y N If yes, please describe any related symptoms: _____

How many hours do you sleep per night? 4-6 6-8 8-10 12+ Do you wake rested? Y N Do you exercise? Y N

Describe Indoor Activities_____

Describe Outdoor Activities_____

Rate Your Appetite: Poor Fair Medium Good Excellent Rate Your Diet: Poor Fair Medium Good Excellent

How many meals do you eat per day? 1 2 3 4 >4 meals Breakfast Lunch Dinner ____ # Snacks

Rate how your current health status affects you in the various aspects of your life:

	No Disability		Mild		Moderate		Severe			Total Disabilty
Family & Home Responsibilities	1	2	3	4	5	6	7	8	9	10
Recreation Activities	1	2	3	4	5	6	7	8	9	10
Social Activities	1	2	3	4	5	6	7	8	9	10
Occupation	1	2	3	4	5	6	7	8	9	10
Interpersonal Relationships	1	2	3	4	5	6	7	8	9	10
Self Care & Independent Living	1	2	3	4	5	6	7	8	9	10

1 Have you felt anxious or on edge? Y N
2 Have you been worrying a lot? Y N
3 Have you been irritable? Y N
4 Have you had a difficult time relaxing? Y N
5 Do you have difficulty falling asleep? Y N
6 Have you neck aches or headaches? Y N
7 Have you had low energy? Y N
8 Have you been worried about your health? Y N
9 Do you get pain at the tip of your tailbone? Y N
10 Does your whole arm or leg feel painful? Y N
11 Does your whole arm or leg feel numb? Y N
12 Does your whole arm or leg feel weak? Y N
13 Have you had any pain free times in the past year? Y N
14 Have you had any intolerances to treatments? Y N
15 Have you had any reactions to treatments? Y N
16 Have your ever been to the emergency room for back pain related reasons? Y N

My signature below indicates that I attest that the information indicated here in these forms is correct.

X_____
Patient's Signature Date

Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort **(Relief Care).** Others are interested in having the cause of the problem as well as the symptoms corrected and relieved **(Corrective Care).** Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care **(Preventive Care).** These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, this prepared recommendation is in incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ Relief Care
- ☐ Corrective Care
- ☐ Preventive Care
- ☐ Check here if you want the doctor to select the type of care appropriate for your condition.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of Chiropractic, medical doctors and physiotherapists who use manual therapy Techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments.

b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.

c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatments, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from Chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by Dr. Nenshi including chiropractic adjustments and those treatments provided by her assistants under her supervision. I intend this consent to apply to all my present and future chiropractic care.

Dated this____ day of _____ 20_____.

_____

Patient Signature

Name: