PATIENT ENTRANCE FORM

Name (Last/First):_____ (Male or Female) Date:_____

Address:_____

E-Mail Address:_____

City, Province:_____ Postal Code:_____

Phone:_____ _____
Home Work

Occupation:_____ Employed By:_____

Spouse's Name: _____ Number of Children:_____

Date of Birth(D/M/Y):_____ Age_____

Alberta Health Care Number:_____

How did you hear about our office: ❒ referral from _____
❒ newspaper
❒ other

If this is a work related injury (WCB), please see the receptionist immediately.

If this is an Automobile Accident Insurance Claim, please see the receptionist immediately.

HEALTH HISTORY:

It is very important that you give us accurate and complete information about your medical history and condition as treatment or procedures recommended will be based on such information.

PRIOR CHIROPRACTIC CARE:

Chiropractor's Name: Dr._____ Town/City:_____

X-rays taken: ❒ YES ❒ NO Date:_____

MEDICAL DOCTOR:

Doctor's Name: Dr._____ Telephone:_____
Date of Last Physical:_____

Habits of Lifestyle:

Do you smoke: ☐ yes If yes, amount _____ ☐ no

Do you consume alcohol: ☐ heavy ☐ moderate ☐ light ☐ none

Do you exercise: ☐ heavy ☐ moderate ☐ light ☐ none

Hours slept per night: ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12+

Do you wake rested: ☐ always ☐ usually ☐ seldomly ☐ rarely

Rate your appetite: ☐ poor ☐ average ☐ excessive

Rate your diet: ☐ poor ☐ average ☐ exceptional

Do you eat regularly: ☐ breakfast ☐ lunch ☐ dinner

Meals eaten per day: ☐ 1 meal ☐ 2 meals ☐ 3 meals ☐ 4+

Daily water consumption: ☐ 0-4 cups ☐ 4-7 cups ☐ 8 or greater cups

Daily coffee consumption: ☐ 0 ☐ 1-2 cups ☐ 3-4 cups ☐ 5-6 cups ☐ > 6

Daily pop consumption: ☐ 0 ☐ 1-2 cans ☐ 3-4 cans ☐ 5-6 cans ☐ > 6

List any vitamins, herbal products, or medications:_____

_____

Do you think you may need to take vitamins and minerals: ☐ yes ☐ no ☐ not sure

List any prior or scheduled surgeries/operations:_____

Have you ever been knocked unconscious: ☐ yes ☐ no

Have you ever been hospitalized: ☐ yes ☐ no

Are you wearing: ☐ custom made orthotics ☐ inner soles ☐ arch supports ☐ heel lifts

Do you have any of the following:

☐ allergies	☐ aneurysm	☐ arthritis	☐ other
☐ cancer	☐ diabetes	☐ epilepsy	
☐ fatigue	☐ hepatitis	☐ depression	
☐ osteoporosis	☐ pneumonia	☐ sinus conditions	
☐ psoriasis	☐ sleeping difficulty	☐ fibromyalgia/chronic	
☐ veneral disease	☐ HIV/AIDS	fatigue	

Please list any family health conditions (siblings, parents, grandparents)

_____

_____

PATIENT PAST HISTORY FORM

Name:_____ Date:_____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional **F = Frequent** **C = Constant**

OFC

SKIN

- ☐☐☐ allergy
- ☐☐☐ chills
- ☐☐☐ convulsions
- ☐☐☐ dizziness
- ☐☐☐ fainting
- ☐☐☐ fevers
- ☐☐☐ headaches
- ☐☐☐ loss of sleep
- ☐☐☐ nervousness
- ☐☐☐ depression
- ☐☐☐ nasal obstruction
- ☐☐☐ sweats

GENITO-URINARY

- ☐☐☐ bed wetting
- ☐☐☐ loss of urine control
- ☐☐☐ prostate trouble

MUSCLE & JOINT

- ☐☐☐ tremors
- ☐☐☐ arthritis
- ☐☐☐ bursitis
- ☐☐☐ foot trouble
- ☐☐☐ hernia
- ☐☐☐ low back pain
- ☐☐☐ neck pain
- ☐☐☐ neck stiffness
- ☐☐☐ pain between shoulders

RESPIRATORY

- ☐☐☐ chest pain
- ☐☐☐ wheezing
- ☐☐☐ chronic cough
- ☐☐☐ difficulty breathing
- ☐☐☐ spitting blood
- ☐☐☐ throat phlegm

EYES, EARS, NOSE & THROAT

- ☐☐☐ colds
- ☐☐☐ crossed eyes
- ☐☐☐ ear aches
- ☐☐☐ ear discharges
- ☐☐☐ ear noises
- ☐☐☐ deafness

OFC

- ☐☐☐ sinus infections
- ☐☐☐ enlarged glands
- ☐☐☐ sore throats
- ☐☐☐ tonsillitis
- ☐☐☐ eye pain
- ☐☐☐ failing vision
- ☐☐☐ far sighted
- ☐☐☐ gum trouble
- ☐☐☐ hay fever
- ☐☐☐ hoarseness
- ☐☐☐ numbness

- ☐☐☐ blood in urine
- ☐☐☐ kidney infection
- ☐☐☐ pus in urine

CARDIO-VASCULAR

- ☐☐☐ rapid heart beat
- ☐☐☐ slow heart beat
- ☐☐☐ swelling of ankles
- ☐☐☐ hardening of arteries
- ☐☐☐ high blood pressure
- ☐☐☐ low blood pressure
- ☐☐☐ pain over heart
- ☐☐☐ poor circulation

GASTRO INTESTINAL

- ☐☐☐ vomiting
- ☐☐☐ vomit blood
- ☐☐☐ nausea
- ☐☐☐ excessive hunger
- ☐☐☐ burping or gas
- ☐☐☐ liver trouble
- ☐☐☐ colitis
- ☐☐☐ colon trouble
- ☐☐☐ constipation
- ☐☐☐ diarrhea
- ☐☐☐ difficult digestion
- ☐☐☐ distention of abdomen
- ☐☐☐ stomach pain
- ☐☐☐ gall bladder trouble
- ☐☐☐ hemorrhoids
- ☐☐☐ intestinal worms
- ☐☐☐ jaundice

OFC

- ☐☐☐ boils
- ☐☐☐ bruise easily
- ☐☐☐ dryness
- ☐☐☐ hives or allergy
- ☐☐☐ itching
- ☐☐☐ skin rash
- ☐☐☐ varicose veins
- ☐☐☐ loss of weight
- ☐☐☐ nosebleeds
- ☐☐☐ neuralgia
- ☐☐☐ near sighted

- ☐☐☐ frequent urination
- ☐☐☐ painful urination
- ☐☐☐ smell of urine

PAIN OR NUMBNESS

- ☐☐☐ shoulders
- ☐☐☐ arms
- ☐☐☐ hands
- ☐☐☐ hips
- ☐☐☐ legs
- ☐☐☐ knees
- ☐☐☐ ankles
- ☐☐☐ feet
- ☐☐☐ painful tail bone
- ☐☐☐ sciatica
- ☐☐☐ swollen joints

FOR WOMEN ONLY

- ☐☐☐ cramps
- ☐☐☐ heavy flow
- ☐☐☐ light flow
- ☐☐☐ irregular cycle
- ☐☐☐ painful cycle
- ☐☐☐ discharge
- ☐☐☐ sore breasts

Menopausal: ☐ yes ☐ no

Pregnant: ☐ yes ☐ no

due date_____

Name_____

State your reason for consulting our office:

_____

_____

_____

Expectations: Which stage of care are you hoping to achieve?

- ☐ Pain & Symptom Relief
- ☐ Wellness Care (optimize health potential)
- ☐ Other
- ☐ Corrective Care (correct cause of pain)

Show area(s) of pain or unusual feeling.

Circle the affected areas on this body and use the appropriate symbols to describe the sensations you are feeling. Mark areas of radiation. Include all affected areas.

Burning
Mark with, ***X***

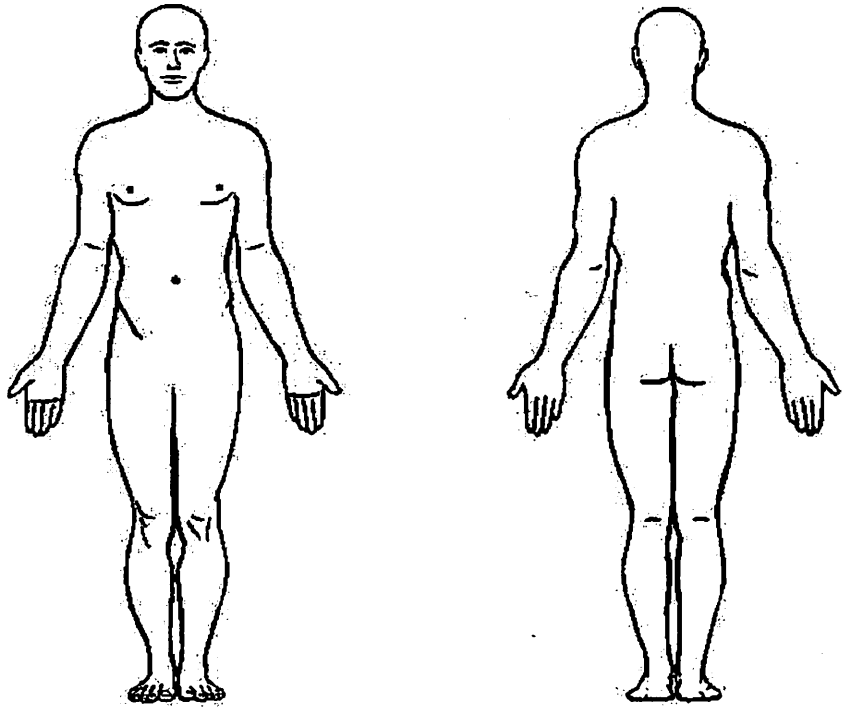
Aching
Mark with, ***A***

Stiffness
Mark with, ***S***

Dull Pain
Mark with, ***D***

Sharp / Stabbing Pain
Mark with, ***P***

Numbness / Pins or Needles
Mark with, ***N***



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____ 20____
Signature of Chiropractor

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

Patient Name: _____ File# _____ Date _____

PLEASE READ INSTRUCTIONS:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - LIFTING
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - WALKING
- ☐ I have not pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one km. without increasing pain.
- ☐ I cannot walk more than ½ km. without increasing pain.
- ☐ I cannot walk more than ¼ km. without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - SITTING
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favourite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

SECTION 7 - SLEEPING
- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain my normal night's sleep is reduced by less than ½.
- ☐ Because of pain my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - TRAVELLING
- ☐ I get no pain whilst travelling.
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain whilst travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Pain Severity Scale:

Rate the severity of your pain by checking one box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

NECK PAIN AND DISABILITY INDEX (Vernon-Mior)

Patient Name: _____ File# _____ Date _____

PLEASE READ INSTRUCTIONS:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - READING

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 - HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - CONCENTRATION

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have alot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 - WORK

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8 - DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I can't drive my car as long as I want with because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 - RECREATION

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all.

Pain Scale:

Rate the severity of your pain by checking one box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain