PRECISION
SPINAL & WELLNESS CENTRE

Phone: 609-8385 Fax:609-8328

CONFIDENTIAL CASE HISTORY

Date: _____

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

----------PERSONAL INFORMATION----------

Name: _____

Gender : ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ W ❑ D Alberta Health Card Number: _____

Address: _____ City: _____

Postal Code: _____ Home Phone: _____ Business Phone: _____

Emergency Contact Name_____ Phone_____

Date of Birth: dd_____mm_____yr_____ e-mail address: _____

Employer: _____ Occupation: _____

Hobbies: (What occupies your spare time?) _____

Spouse's or Partner's Name: _____Children(number)_____

How did you hear about our office? _____

----------HEALTH INFORMATION----------

Have you ever been to a chiropractor before? ❑ No Yes Doctor's Name: _____

When was your last visit? _____ What was the problem? _____

What was your result? _____

Have you had previous healthcare for this problem? ❑ Yes ❑ No

Where? _____ When? _____

Were x-rays taken? _____

IS THERE ANY CHANCE YOU COULD BE PREGNANT? ❑ Yes ❑ No

*******If You think you **are pregnant** please let the doctor know******

PLEASE INDICATE THE FIRST DAY OF YOUR LAST MENSTRUAL CYCLE_____

----------REASON FOR CONSULTING OUR OFFICE----------

❑ I have a specific problem and require help only with this problem.

❑ After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.

❑ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.

❑ I have no symptoms and feel well. I am interested in strategies to help me to continue to feel well, or even better.

Is this a work related injury? Yes___ No___

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1) What is your primary health concern?_____

How long have you had this condition?_____

How often do you notice it? Always --- Daily --- Weekly --- Monthly --- Yearly --- other_____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

One a scale of 1-10 describe your level of discomfort (0 none 10 severe) _____

Have you had this or similar conditions in the past? ❑ No ❑ Yes, and when? _____

If you are experiencing discomfort, how would you describe it? (dull, sharp, heavy..)_____

Does the sensation travel anywhere?_____

What activities aggravate your condition?_____

What makes it better? _____

What do you think is the cause of your problem?_____

What is your health expectation?_____

Is this condition interfering with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other _____

On a scale of 1-10 describe your stress level:

(1=none, 10= extreme) Occupational:_____ Personal:_____

How long has it been since you really felt well? _____

2) What is your Secondary health concern?_____

How long have you had this condition?_____

How often do you notice it? Always --- Daily --- Weekly --- Monthly --- Yearly --- other_____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

One a scale of 1-10 describe your level of discomfort (0 none 10 severe) _____

Have you had this or similar conditions in the past? ❑ No ❑ Yes, and when? _____

If you are experiencing discomfort, how would you describe it? (dull, sharp, heavy..)_____

Does the sensation travel anywhere?_____

What activities aggravate your condition?_____

What makes it better? _____

What do you think is the cause of your problem?_____

3) Other health concerns?_____

How long have you had this condition?_____

How often do you notice it? Always --- Daily --- Weekly --- Monthly --- Yearly --- other_____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

One a scale of 1-10 describe your level of discomfort (0 none 10 severe) _____

Have you had this or similar conditions in the past? ❑ No ❑ Yes, and when? _____

If you are experiencing discomfort, how would you describe it? (dull, sharp, heavy..)_____

Does the sensation travel anywhere?_____

What activities aggravate your condition?_____

What makes it better? _____

What do you think is the cause of your problem?_____

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Has there been any medical diagnosis of your complaint? ❑No ❑ Yes , if yes list the Dr.'s name and

diagnosis: _____

Are there any other Health conditions that we should know about?_____

List surgeries, broken bone, and major illnesses (including childhood):_____

_____

_____

Any family health conditions or problems: □ Yes □ No Please list: _____

Age of Mattress: _____ Comfortable: ❑ Yes ❑ No Do you sleep on your stomach? ❑ Yes ❑ No

Do you wear ❑ Heel Lifts ❑ Sole Lifts ❑ Inner soles ❑ Arch supports ❑ Orthotics

Is your problem the result of a work injury or an auto accident?

Have you been in an auto accident: ❑ Never ❑ Past year ❑ Past 5 years ❑ Over 5 years

Is there or might there be a lawyer involved? ❑ Yes ❑ No

Description of accident:_____

_____

_____

Have you had any significant injury in your lifetime: ❑ None ❑ Past year ❑ Past 5 years ❑ other_____

Description of accident: _____

_____

Have you ever been knocked unconscious: □ Yes□ No□ Don't know

If so, for how long & describe what happened:_____

Date of most recent physical examination: _____

----------HABITS OF LIFESTYLE----------

Do you smoke:□ Yes□ No ____Pack(s)/day Alcohol Consumption: □ Yes□ No #drinks weekly:____
Exercise/week (in hours)_____ Average Intensity Level (circle): Low—Moderate-- High
Activity types: _____ Stretching:_____hr/wk Resistance training _____hr/wk
Do you drink beverages with caffeine: □ Yes□ No If yes, how many glasses daily: _____
How many glasses of water do you drink per day: 0 –1--2– 3--4—5—6—7—8—9—10—11---12+
Rate your sleep, hours per night: 4 5 6 7 8 9 10 11 12+
Do you wake rested: □ Yes □ No
Do you feel overly fatigued during the course of a day: □ Yes□ No
Rate your diet: 1)Poor 2)Fair 3)Medium 4)Good 5)Excellent
Do you eat regularly: □Breakfast □Lunch □Dinner
List any Prescription Drugs, Over the counter Drugs, Vitamins and Natural Supplements you are currently taking and WHY?:

What are you currently taking?	What is it for?

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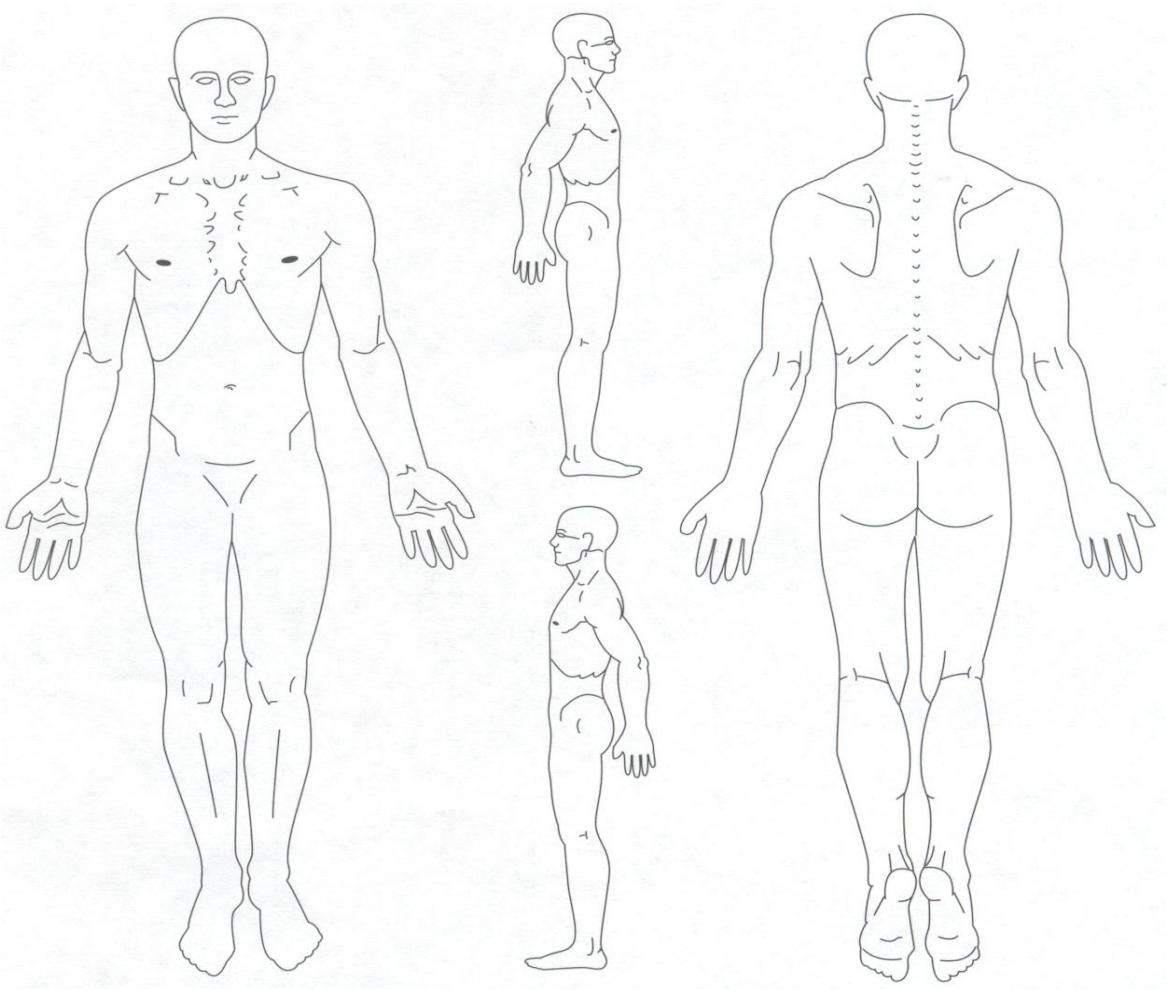
Please mark the areas on the figures of pain and/or discomfort:

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull	**S = Stabbing/Sharp**
B = Burning	**T = Tingling (Pins & Needles)**
N = Numb	**C = Cramping**

R **L** **L** **R**



PATIENT HISTORY FORM

Please check the appropriate box for any of the following symptoms that you may have.
C= Constant F= Frequent *(weekly)* **0= Occasional** *(monthly/yearly)*

C	F	O	NEUROLOGICAL	C	F	O	Con't	C	F	O	PAIN,NUMBNESS, TENSION
☐	☐	☐	Lower resistance	☐	☐	☐	Failing vision	☐	☐	☐	Shoulders
☐	☐	☐	Allergy	☐	☐	☐	Far sighted	☐	☐	☐	Arms
☐	☐	☐	Chills	☐	☐	☐	Hay Fever	☐	☐	☐	Hands
☐	☐	☐	Convulsions	☐	☐	☐	Hoarseness	☐	☐	☐	Hips
☐	☐	☐	Dizziness	☐	☐	☐	Nasal obstruction	☐	☐	☐	Legs
☐	☐	☐	Fainting	☐	☐	☐	Near sighted	☐	☐	☐	Knees
☐	☐	☐	Fevers	☐	☐	☐	Nosebleeds	☐	☐	☐	Ankles
☐	☐	☐	Headaches	**C**	**F**	**O**	**CARDIO-VASCULAR**	☐	☐	☐	Feet
☐	☐	☐	Migraines	☐	☐	☐	Rapid heart beats	☐	☐	☐	Painful tail bone
☐	☐	☐	Loss of sleep	☐	☐	☐	Slow heart beats	☐	☐	☐	Sciatica
☐	☐	☐	Nervousness	☐	☐	☐	Swelling of ankle	☐	☐	☐	Swollen joints
☐	☐	☐	Depression	☐	☐	☐	Hardening of arteries	**C**	**F**	**O**	**WOMEN ONLY**
☐	☐	☐	Neuralgia/nerve pain	☐	☐	☐	High blood pressure	☐	☐	☐	Cramps
☐	☐	☐	Numbness	☐	☐	☐	Low blood pressure	☐	☐	☐	Heavy flow
☐	☐	☐	Sweats	☐	☐	☐	Pain over heart	☐	☐	☐	Light flow
☐	☐	☐	Loss of weight	☐	☐	☐	Poor circulation	☐	☐	☐	Irregular cycle
☐	☐	☐	Tremors	**C**	**F**	**O**	**GASTRO INTESTINAL**	☐	☐	☐	Painful cycle
C	**F**	**O**	**MUSCLE & JOINT**	☐	☐	☐	Excessive hunger	☐	☐	☐	Discharge
☐	☐	☐	Arthritis	☐	☐	☐	Burping or gas	☐	☐	☐	Sore breasts
☐	☐	☐	Bursitis	☐	☐	☐	Liver troubles				
☐	☐	☐	Foot trouble	☐	☐	☐	Colitis				
☐	☐	☐	Hernia	☐	☐	☐	Colon troubles				
☐	☐	☐	Low back pain	☐	☐	☐	Constipation				
☐	☐	☐	Neck pain	☐	☐	☐	Diarrhea				
☐	☐	☐	Neck stiffness	☐	☐	☐	Difficult digestion				
☐	☐	☐	Pain between shoulder	☐	☐	☐	Distension of abdomen				
☐	☐	☐	Spinal curvature	☐	☐	☐	Stomach pain				
☐	☐	☐	Jaw clicking	☐	☐	☐	Gall bladder trouble				
☐	☐	☐	Jaw pain	☐	☐	☐	Hemorrhoids				
C	**F**	**O**	RESPIRATORY	☐	☐	☐	Intestinal worms				
☐	☐	☐	Chest pain	☐	☐	☐	Jaundice				
☐	☐	☐	Chronic cough	☐	☐	☐	Poor appetite				
☐	☐	☐	Difficulty breathing	☐	☐	☐	Nausea				
☐	☐	☐	Spitting blood	☐	☐	☐	Vomiting				
☐	☐	☐	Throat phlegm	☐	☐	☐	Vomit blood				
☐	☐	☐	Wheezing	**C**	**F**	**O**	**SKIN**				
C	**F**	**O**	**EYES,EARS,NOSE,THROAT**	☐	☐	☐	Boils				
☐	☐	☐	Colds	☐	☐	☐	Bruise easily				
☐	☐	☐	Crossed eye	☐	☐	☐	Dryness				
☐	☐	☐	Deafness	☐	☐	☐	Hives or allergy				
☐	☐	☐	Dental decay	☐	☐	☐	Itching				
☐	☐	☐	Asthma	☐	☐	☐	Skin rash				
☐	☐	☐	Ear aches/infections	☐	☐	☐	Varicose veins				
☐	☐	☐	Ringing in ears	**C**	**F**	**O**	**GENTIO-URINARY**				
☐	☐	☐	Sinus infections	☐	☐	☐	Bed wetting				
☐	☐	☐	Enlarged glands	☐	☐	☐	Blood in urine				
☐	☐	☐	Enlarged thyroid	☐	☐	☐	Frequent urination				
☐	☐	☐	Sore throat	☐	☐	☐	Sexual dysfunction				
☐	☐	☐	Tonsillitis	☐	☐	☐	Urinary troubles				
☐	☐	☐	Eye pain								

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MEDICAL DOCTOR:

Name: _____ Date of Last Appointment: _____

MEDICAL SPECIALIST:

Name: _____Specialty: _____

Date of Last Appointment: _____

DENTIST:

Name: _____Date of Last Appointment: _____

DENTAL SPECIALIST:

Name: _____Specialty: _____
Date of Last Appointment:_____

List Past Dental Procedures:

_____

_____

_____

NATUROPATH/NUTRITIONIST:

Name: _____ Date of Last Appointment: _____

MASSAGE THERAPIST

Name: _____ Date of Last Appointment: _____

PHYSICAL THERAPIST:

Name: _____ Date of Last Appointment: _____

FITNESS FACILITY:

Name: _____ Trainer_____

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PRIVACY & DISCLOSURE OF USING FIRST AND LAST NAME

As one of our patients, we hold both your health and your privacy in the highest esteem. We would like your permission to confer with other members of your health care team as well as with other practitioners who we feel may be of assistance.

If there is anyone you are currently aware of that you would like us not to contact, please list his or her names in the area provided below. We will use our professional discretion to protect your privacy, while ensuring that you have the best opportunities for wellness that we can provide.

I do not want the following individual to be contacted:

This office is required, by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of legal duties and privacy practices with respect to the use of your name.

By way of signing this form, I release this office from all liability and authorize the use of my first and last for the purpose of announcing me into a room or around the office in the presence of others and your email for monthly clinic update newsletter. We also ask your permission to thank those who referred you to our practice.

NAME(print):_____

DATE_____

Signature:_____
(patient/guardian)

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