# CHIROPRACTIC HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive treatments. If your health status changes, please let us know. All information collected is confidential, except as required or allowed by law or to facilitate diagnosis or treatment.

## PERSONAL HISTORY

DATE: DD / MM / YYYY

FIRST NAME | LAST NAME

ADDRESS | CITY | POSTAL CODE | DD / MM / YYYY DATE OF BIRTH

( ) HOME PHONE | ( ) MOBILE PHONE | EMAIL ADDRESS

## EMPLOYER INFORMATION

EMPLOYER | OCCUPATION

ADDRESS | CITY | POSTAL CODE | ( ) WORK PHONE

## HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet (Google, Website) ☐ Phone Book ☐ Massage Therapist ☐ Friend / Family _____

☐ Brochure ☐ Medical Doctor ☐ Personal Trainer ☐ Other _____

## PREVIOUS CHIROPRACTIC CARE ☐ YES ☐ NO

CHIROPRACTORS NAME | DD / MM / YYYY DATE OF LAST VISIT (APPROX.)

CLINIC NAME | **X-RAYS** ☐ **YES** ☐ **NO**

## DO YOU WEAR FOOT ORTHOTICS ☐ YES ☐ NO

HOW LONG HAVE YOU WORN THEM? | HOW LONG SINCE LAST PAIR?

MADE BY

## PRIMARY CARE MEDICAL DOCTOR

I authorize Target Therapeutics to send a report. ☐ **YES** ☐ **NO** **INITIAL** _____

DOCTORS NAME | CITY

## MASSAGE THERAPIST

I authorize Target Therapeutics to send a report. ☐ **YES** ☐ **NO** **INITIAL** _____

THERAPISTS NAME | CLINIC NAME

## PAST MEDICAL HISTORY (Please indicate conditions you are experiencing and/or experienced.)

### GENERAL

☐ Numbness/Tingling ☐ Asthma
☐ Sinus Problems ☐ Cancer
☐ Loss of Sensation ☐ Fever
☐ Vision Loss ☐ Sweats
☐ Blurred Vision ☐ Fainting
☐ Eye Pain ☐ Diabetes
☐ Hearing Loss ☐ Allergies
☐ Earache ☐ Epilepsy
☐ Headache

### MUSCLES & JOINTS

☐ Stiffness ☐ Shoulder Pain
☐ Weakness ☐ Osteoporosis
☐ Arthritis ☐ Upper Back
☐ Back Pain ☐ Low Back
☐ Neck Pain ☐ Mid Back
☐ Knee Pain ☐ Swollen Joints
☐ Arm Pain ☐ Other
☐ Leg Pain _____

### RESPIRATORY

☐ Chronic Cough ☐ Emphysema
☐ Chest Pain ☐ Chronic Bronchitis
☐ Asthma

### INFECTIONS

☐ Hepatitis ☐ Skin Conditions
☐ TB ☐ Other
☐ HIV _____

### GASTROINTESTINAL

☐ Indigestion
☐ Nausea
☐ Diarrhea
☐ Colitis
☐ Poor Appetite
☐ Excessive Gas
☐ Constipation
☐ Ulcers

### CARDIOVASCULAR

☐ Heart Disease
☐ Poor Circulation
☐ Swelling in Ankles
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Heart Attack
☐ Phlebitis
☐ Stroke/CVA
☐ Pacemaker
☐ Varicose Veins

Please specify any other medical conditions you may have that are not listed: _____

Special Note (presence of internal pins, wires, artificial joints, special equipment): _____

Had an accident? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Had an operation? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Had a fracture? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Been hospitalized? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Do you exercise regularly? ☐ **YES** ☐ **NO** If **YES**, how often: _____

## MEDICATION / SUPPLEMENTS

☐ Anti-inflammatory ☐ Blood Pressure ☐ Other: _____
☐ Antibiotics ☐ Depression _____
☐ Cholesterol ☐ Pain Killers _____
☐ Anti-anxiety ☐ Blood Thinners _____
☐ Muscle Relaxants ☐ Vitamins/Herbs _____
☐ Antacids ☐ Essential Fats _____

## STRESS LEVELS

☐ **LOW**
☐ **MODERATE**
☐ **HIGH**

# CHIROPRACTIC HEALTH HISTORY FORM

## CURRENT HEALTH CONDITION

Primary Complaint (Reason for coming in): _____

Other Doctors or Therapists for this condition: ☐ **YES** ☐ **NO** If **YES**, who treated you: _____

What was the treatment and result: _____ When did this condition begin: _____

Has it occurred before: ☐ **YES** ☐ **NO** If **YES**, when: _____ How many times: _____

Is it: ☐ Job Related ☐ Car Related ☐ Home Related ☐ Stress Related ☐ Injury ☐ Other: _____

Is the pain getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes and Goes ☐ Other: _____

**What aggravates your condition?**

☐ Sitting ☐ Lifting ☐ Heat
☐ Standing ☐ Lying ☐ Cold
☐ Bending ☐ Walking ☐ Other: _____

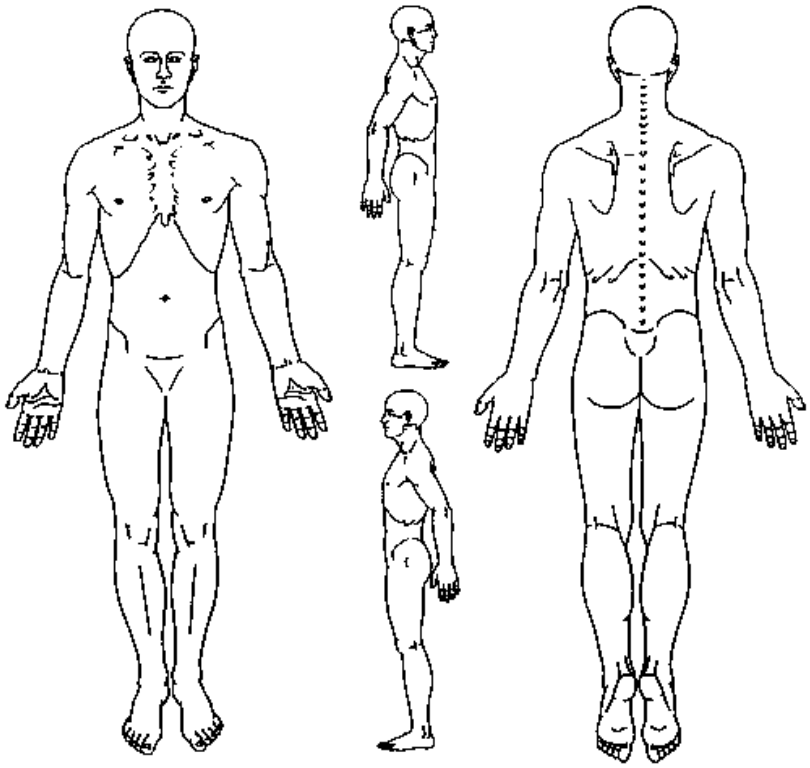
**What makes you feel better?**

☐ Sitting ☐ Lifting ☐ Heat
☐ Standing ☐ Lying ☐ Cold
☐ Bending ☐ Walking ☐ Other: _____

Please indicate the type(s) of pain you are feeling: ☐ Sharp ☐ Achy ☐ Numb ☐ Burning ☐ Tightness

Please circle the severity of your pain at this time: NO PAIN **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** WORST PAIN EVER

On the diagrams below use the symbol(s) and draw the location(s) of your pain: Sharp **O** Achy **X** Numb **+** Burning **^** Tightness **#**



## EXAMINATION REPORT DO NOT COMPLETE FOR DOCTOR USE ONLY ☐ Dr. Dziak ☐ Dr. Plante ☐ Kevin Kelly

**LOCATION**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ☐ Low Back | ☐ L | ☐ R | ☐ Knee | ☐ L | ☐ R |
| ☐ Mid Back | ☐ L | ☐ R | ☐ Ankle | ☐ L | ☐ R |
| ☐ Upper Back | ☐ L | ☐ R | ☐ Foot | ☐ L | ☐ R |
| ☐ Neck | ☐ L | ☐ R | ☐ Toe | ☐ L | ☐ R |
| ☐ Head | ☐ L | ☐ R | ☐ Wrist | ☐ L | ☐ R |
| ☐ Rib(s) | ☐ L | ☐ R | ☐ Hand | ☐ L | ☐ R |
| ☐ Shoulder | ☐ L | ☐ R | ☐ Finger | ☐ L | ☐ R |
| ☐ Elbow | ☐ L | ☐ R | ☐ Hip | ☐ L | ☐ R |

**THERAPIES**

| | |
|---|---|
| ☐ JRT | ☐ Strengthening |
| ☐ ART | ☐ Physiotherapy |
| ☐ RMT | ☐ Medical Acupuncture |
| ☐ Stretching | ☐ Electric Stimulation |
| ☐ Traction | ☐ Low Intensity Laser |
| ☐ McKenzie | ☐ X-RAYS (Location) |
| ☐ Orthotics | _____ |
| ☐ Ultrasound | |

**COMPLICATION FACTORS**

| | |
|---|---|
| ☐ Age | ☐ Chronic Conditions |
| ☐ Fitness Level | ☐ Physiotherapy |
| ☐ Re-Injury | ☐ Other |
| ☐ Work | _____ |
| ☐ Motivation | _____ |
| ☐ Weight | _____ |
| ☐ Diabetes | _____ |
| ☐ Posture | |

**DIAGNOSIS** ☐ **Acute** ☐ **Chronic**

_____

_____

# 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