



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	DATE OF BIRTH DD / MM / YYYY	
()	()	EMAIL ADDRESS (For Appointment Reminders)		
HOME PHONE	MOBILE PHONE			
EMPLOYER INFORMATION				
EMPLOYER		OCCUPATION		
ADDRESS	CITY	POSTAL CODE	() WORK PHONE	
HOW DID YOU HEAR ABOUT OUR OFFICE?				
<input type="checkbox"/> Internet <input type="checkbox"/> Phone Book <input type="checkbox"/> Massage Therapist <input type="checkbox"/> Friend / Family _____ <input type="checkbox"/> Brochure <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Personal Trainer <input type="checkbox"/> Other _____				
PREVIOUS CHIROPRACTIC CARE <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER PRACTITIONERS SEEN			
_____ CHIROPRACTOR'S NAME DD / MM / YYYY DATE OF LAST VISIT (APPROX.) _____ CLINIC NAME X-rays <input type="checkbox"/> YES <input type="checkbox"/> NO	MESSAGE THERAPY <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ OSTEOPATHY <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ PHYSIOTHERAPY <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ ACUPUNCTURE <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ OTHER _____ <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____			
PRIMARY CARE MEDICAL DOCTOR	DO YOU WEAR FOOT ORTHOTICS <input type="checkbox"/> YES <input type="checkbox"/> NO			
I authorize Target Therapeutics to send a report. <input type="checkbox"/> NO <input type="checkbox"/> YES INITIAL _____ _____ DOCTORS NAME CITY	HOW LONG HAVE YOU WORN THEM? _____ HOW LONG SINCE YOUR LAST PAIR? _____			

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PAST MEDICAL HISTORY

<div style="background-color: #e0e0e0; padding: 2px; text-align: center; font-weight: bold; margin-bottom: 5px;">GENERAL</div> <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Vision Loss <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Earache <input type="checkbox"/> Headache <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Fainting <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fever <input type="checkbox"/> Sweats <input type="checkbox"/> Allergies	<div style="background-color: #e0e0e0; padding: 2px; text-align: center; font-weight: bold; margin-bottom: 5px;">MUSCLES & JOINTS</div> <input type="checkbox"/> Stiffness <input type="checkbox"/> Weakness <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Knee Pain <input type="checkbox"/> Arm Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Upper Back <input type="checkbox"/> Low Back <input type="checkbox"/> Mid Back <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Other _____	<div style="background-color: #e0e0e0; padding: 2px; text-align: center; font-weight: bold; margin-bottom: 5px;">GASTROINTESTINAL</div> <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Colitis <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Excessive Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Ulcers	<div style="background-color: #e0e0e0; padding: 2px; text-align: center; font-weight: bold; margin-bottom: 5px;">CARDIOVASCULAR</div> <input type="checkbox"/> Heart Disease <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Swelling in Ankles <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Phlebitis <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Pacemaker <input type="checkbox"/> Varicose Veins
		<div style="background-color: #e0e0e0; padding: 2px; text-align: center; font-weight: bold; margin-bottom: 5px;">INFECTIONS</div> <input type="checkbox"/> Hepatitis <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> Skin Conditions <input type="checkbox"/> Other _____	<div style="background-color: #e0e0e0; padding: 2px; text-align: center; font-weight: bold; margin-bottom: 5px;">RESPIRATORY</div> <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Chest Pain <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis

- Please specify any other medical conditions you may have that are not listed: _____
- Presence of internal pins, wires, artificial joints, special equipment): _____
- Had an accident? YES NO
 If YES, please describe: _____
- Had an operation? YES NO
 If YES, please describe: _____
- Had a fracture? YES NO
 If YES, please describe: _____
- Been hospitalized? YES NO
 If YES, please describes: _____
- Have you ever had cancer? YES NO
 If YES, please describe: _____

<div style="background-color: #e0e0e0; padding: 2px; font-weight: bold; margin-bottom: 5px;">MEDICATION / SUPPLEMENTS</div> <input type="checkbox"/> Anti-inflammatory <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Other: _____ <input type="checkbox"/> Antibiotics <input type="checkbox"/> Depression _____ <input type="checkbox"/> Cholesterol <input type="checkbox"/> Pain Killers _____ <input type="checkbox"/> Anti-anxiety <input type="checkbox"/> Blood Thinners _____ <input type="checkbox"/> Muscle Relaxants <input type="checkbox"/> Vitamins/Herbs _____ <input type="checkbox"/> Antacids <input type="checkbox"/> Essential Fats _____	<div style="background-color: #e0e0e0; padding: 2px; font-weight: bold; margin-bottom: 5px;">STRESS LEVELS</div> <input type="checkbox"/> LOW <input type="checkbox"/> MODERATE <input type="checkbox"/> HIGH
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CURRENT HEALTH CONDITION

Primary Complaint (Reason for coming in): _____

Has it occurred before: NO YES _____ 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: _____

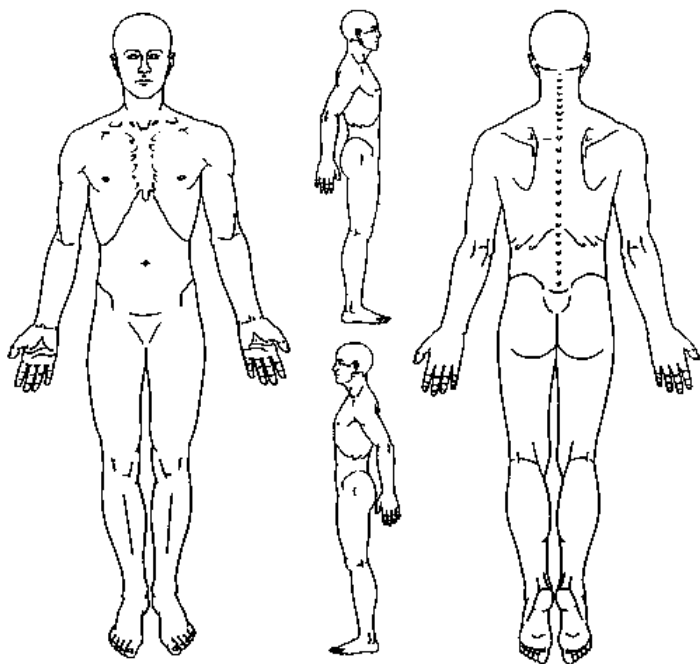
What makes you feel better?

- 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

LOCATION	THERAPIES	COMPLICATION FACTORS
<input type="checkbox"/> Low Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Mid Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Upper Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Neck <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Toe <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Head <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Rib(s) <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Finger <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> JRT <input type="checkbox"/> Strengthening <input type="checkbox"/> ART <input type="checkbox"/> Physiotherapy <input type="checkbox"/> RMT <input type="checkbox"/> Medical Acupuncture <input type="checkbox"/> Stretching <input type="checkbox"/> Electric Stimulation <input type="checkbox"/> Traction <input type="checkbox"/> Low Intensity Laser <input type="checkbox"/> McKenzie <input type="checkbox"/> X-RAYS (Location) <input type="checkbox"/> Orthotics <input type="checkbox"/> Ultrasound	<input type="checkbox"/> Age <input type="checkbox"/> Chronic Conditions <input type="checkbox"/> Fitness Level <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Re-Injury <input type="checkbox"/> Other <input type="checkbox"/> Work <input type="checkbox"/> Motivation <input type="checkbox"/> Weight <input type="checkbox"/> Diabetes <input type="checkbox"/> Posture
DIAGNOSIS <input type="checkbox"/> Acute <input type="checkbox"/> Chronic		
_____ _____ _____		

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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, muscle 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, an increase in pre-existing symptoms of pain or stiffness will only last 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.

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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)

Signature of Patient (or Legal Guardian)

Date

Signature of Chiropractor

Date