CONSULTATION ADMITTANCE FORM

Last Name: _____ First Name:_____ Sex: M / F

Address:_____ City_____ Postal Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Cell Phone Provider: _____

E-mail: _____ Occupation:_____ Marital Status:_____

No. of children:_____ Birth date (DD/MM/YYYY):_____ Alberta Health Care #:_____

By whom were you referred? _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason for appointment? _____

When did your condition begin? _____

Have you ever had similar problems? □ Yes □ No

Have you had X-rays, MRI or other tests for this condition? What tests and when? _____

_____

Is this condition related to: Work? □ Yes □ No Has your employer been notified? □ Yes □ No

Motor vehicle accident? □ Yes □ No Date of injury: _____

Can you perform your daily home activities? □ Yes □ Yes, only with help □ Not at all

Can you perform your daily work activities? □ All activities □ Only some □ Not at all

Describe your stress level: □ None □ mild □ Moderate □ High

Do you exercise? □ Daily □ Occasionally □ Not at all

Is this condition interfering with your: □ Work □Sleep □ Daily Routine □ Other_____

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):_____

_____

_____

Have you had previous chiropractic care? □ Yes □ No Doctor: _____ Date: _____

Family doctor name: _____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) _____

_____

I understand that there is no longer Alberta Health Care coverage for chiropractic care and that I am personally responsible for the entire balance of the Doctor's recognized fee schedule.

Date: _____ Patient Signature: _____

PERSONAL HEALTH HISTORY

*Many health problems are the result of hereditary spinal weakness. This information about your **immediate family members** will give us a better picture of your total health.*

Do you or a family member have a history of the following? If so please circle:

Aids	Alcoholism	Allergies	Arthritis	Asthma
Bed Wetting	Cancer	Cardiovascular Disease	Depression	Diabetes
Epilepsy	Hyperactivity	Learning Disability	Lumbago	Multiple Sclerosis
Schizophrenia	Stomach Ulcers	Venereal Disease	Other _____	

PERSONAL HEALTH HISTORY

Below is a list of conditions which may seem unrelated to your appointment. However, these questions must be answered carefully as these problems can affect you overall diagnosis, treatment plan and possibility of being accepted for care. Circle those which apply.

Appendicitis	Malaria	Chicken Pox	Alcoholism
Scarlet Fever	Tuberculosis	Diabetes	Venereal Infection
Diphtheria	Whooping Cough	Cancer	Arthritis
Typhoid Fever	Anemia	Heart Disease	Epilepsy
Pneumonia	Measles	Goiter	Lumbago
Rheumatic Fever	Mumps	Influenza	Mental Disorder
Polio	Small Pox	Pleurisy	Eczema

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL

- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain/stiffness
- ☐ Walking problems
- ☐ Difficulty chewing / Clicking jaw

NERVOUS SYSTEM CODE

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling extremities

GENERAL CODE

- ☐ Allergies
- ☐ Loss of sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive appetite
- ☐ Excessive thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gas/Bloating after meals
- ☐ Heart burn
- ☐ Black/Bloody stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder trouble
- ☐ Painful/Excessive urination
- ☐ Discoloured urine

C-V-R CODE

- ☐ Chest pain
- ☐ Short breath
- ☐ Blood pressure problems
- ☐ Irregular heart beat
- ☐ Heart problems
- ☐ Lung problems/Congestion
- ☐ Varicose veins
- ☐ Ankle swelling

EENT CODE

- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Ear aches
- ☐ Hearing difficulties
- ☐ Stuffed nose

MALE/FEMALE CODE

- ☐ Menstrual irregularity
- ☐ Menstrual cramping
- ☐ Vaginal pain/infection
- ☐ Breast pain/lumps
- ☐ Prostate/Sexual dysfunction
- ☐ Genital herpes

FEMALES ONLY

When was your last period?

_____

Are you pregnant?

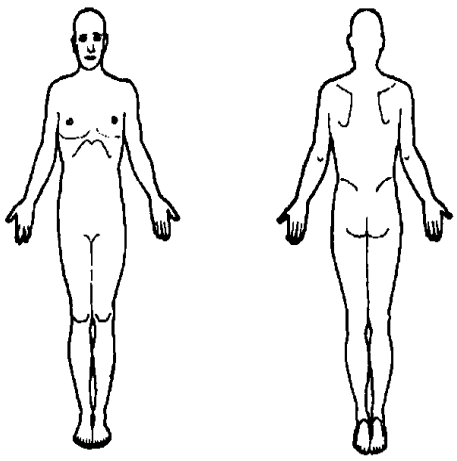
- ☐ Yes
- ☐ No
- ☐ Maybe

HEALTH HISTORY QUESTIONNAIRE

Have you ever been diagnosed or told you have any of the following?
Please circle the correct response.

1.	High blood pressure.....	Yes	No
2.	Hardening of the arteries (arteriosclerosis).....	Yes	No
3.	Diabetes.....	Yes	No
4.	Tuberculosis.....	Yes	No
5.	Cancer, Where?	Yes	No
6.	Heart or blood diseases.....	Yes	No
7.	Bone spurs on the neck bones (cervical sprain).....	Yes	No
8.	Whiplash injury (flexion-extension injury, cervical sprain).....	Yes	No
9.	Have you or any of your relatives ever suffered a stroke?	Yes	No
10.	Were you ever a smoker? From_____ To_____	Yes	No
11.	Do you take any medication on a regular basis?.....	Yes	No
12.	Visual disturbances (blurring, loss, double)	Yes	No
13.	Hearing disturbances (loss, ringing, other noise).....	Yes	No
14.	Slurred speech or other speech problems.....	Yes	No
15.	Difficulty swallowing.....	Yes	No
16.	Dizziness.....	Yes	No
17.	Loss of consciousness, even momentary blackouts.....	Yes	No
18.	Numbness, loss of sensation, strength or weakness in the face, fingers hands, arms, legs or any other parts of the body…..	Yes	No
19.	Sudden collapse without loss of consciousness.....	Yes	No

Indicate the location of your pain by shading in the appropriate area



Indicate the severity of the pain by circling a number.

| 0 1 2 3 4 5 6 7 8 9 10 |

No Pain Extreme Pain

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:

20. **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.
21. **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.
22. **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.
23. **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.
24. **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.
25. **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