

ACQUAINTANCE INFORMATION

The data on this confidential form is essential if we are to render the best professional care.
We appreciate your co-operation in filling it out so that we will have accurate records.
Please Print - Thank You

DATE	PERSONAL INFORMATION		E-MAIL ADDRESS
PATIENT'S LAST NAME	FIRST NAME		HOME PHONE
HOME ADDRESS	CITY/TOWN		POSTAL CODE
DATE OF BIRTH DAY/MONTH/YEAR	OCCUPATION		BUSINESS PHONE
EMPLOYER	BUSINESS ADDRESS		
MARITAL STATUS	NAME OF SPOUSE	OCCUPATION	BUSINESS PHONE
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?	WHO MAY WE "THANK" FOR REFERRING YOU TO OUR OFFICE?		
NO. AND AGES OF CHILDREN			

PROVINCIAL HEALTH CARE INSURANCE PLAN

ALBERTA HEALTH CARE NUMBER	SOCIAL INSURANCE NUMBER
OTHER HEALTH INSURANCE	PLAN/GROUP POLICY NUMBER

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here _____ **"WISH TO HAVE CHIROPRACTIC WELLNESS SERVICES"** and skip to **"FAMILY HEALTH PROFILE"**. Others need to answer the following brief questions.

YOUR HEALTH PROFILE

Have you had previous Chiropractic care? No Yes Doctor _____ City _____

What were you treated for? _____ Were X-Rays taken? Yes No

What is your major complaint? _____

How long have you had this condition? _____

Is this condition getting progressively worse? No Yes When? _____

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

What activities aggravate your condition? _____

What makes it feel better? _____

Have you had this or a similar condition in the past? No Yes When? _____

Other complaints: *(please list)* _____

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

Please list any surgical operations: _____

And years they were performed _____

Name of medical doctor _____

Are you currently taking

<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> Insulin	<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Nerve Pills
<input type="checkbox"/> Pain Killers	<input type="checkbox"/> Pep Pills	<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Vitamins

Other medications _____

YOUR HEALTH PROFILE (CONTINUED)

Age of mattress _____ Comfortable Uncomfortable
How do you sleep? On Back On Side On Stomach A Combination
Have you ever been in an auto accident? No Yes (describe) _____

Have you had any other personal injury? Past Year Past 5 Years Over 5 Years None
Or accident? (describe) _____

Interest & Hobbies: _____

Smoke No Yes How Much? _____

What are your objectives in consulting this office? _____

What are your health objectives once you feel better? _____

Have you ever been to a doctor who put you on a health development program? No Yes

If yes, What was their name: _____

How long did you stay on the program? _____

What were the results? _____

Were the results permanent? No Yes

Are you as healthy today as you were 5 years ago? No Yes

If yes, what were your strategies? _____

Do you plan to be healthier 5 years from now than you are today? No Yes

If yes, what strategies do you plan on implementing to do this? _____

If no, what strategies could you implement? _____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

Others _____

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

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Eczema |

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

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Leg Pain
- Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM CODE

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Depression
- 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
- Gall Bladder Problems
- Weight Changes
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

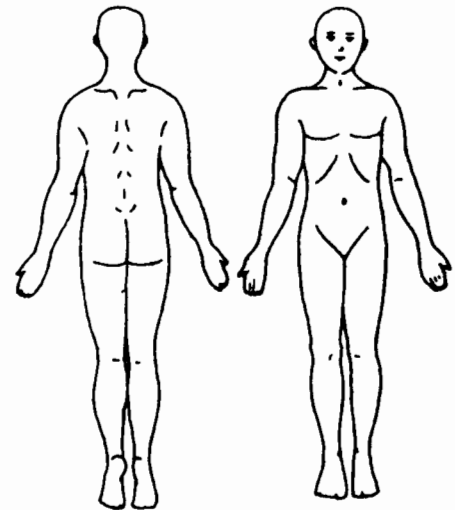
MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes

FEMALES ONLY:

When was your last period? _____

Are you pregnant? Yes No Maybe



Please outline on the diagram the area of your discomfort.

WHY CHIROPRACTIC?

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care Corrective Care Comprehensive Care Check here if you want the Doctor to select the type of care appropriate for your condition.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment.

In particular you should note;

- A) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
- B) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;
- C) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years, and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient or Parent/Guardian Signature

Name: *(please print)*

Verification of Signature

Name: *(please print)*