Natural Care CLINIC

Professional Regulated Therapies

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Chiropractic Intake Form – Bill Adams, DC

Patient History

Name_____

Date _____

Address _____

Province_____ Postal Code_____

H. Phone (____) _____ W. Phone (____) _____

Date of Birth_____ Age_____

How did you find our clinic? _____

Occupation _____

Employer_____

Emergency Contact_____ Relation_____

Emergency Contact telephone #_____

Number of Children/Ages _____

Spouses Occupation_____

Have you ever received chiropractic care? Yes or No

Symptoms and Present State of Health

Present complaint/reason for seeking care in this office:

Major _____

Minor (secondary) _____

Pain or problem started _____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____

Does this pain shoot, radiate, or travel in your body? Yes or No

If yes, where? _____

Are you experiencing numbness or tingling in any area of your body? Yes or No

If yes, where? _____

Since it began, is the pain: O Same O Better O Worst

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is this condition worse during certain times of the day? _____

Is this condition interfering with Work? _____ Sleep? _____ Routine? _____ Other?_____

Is this condition progressively getting worse? _____

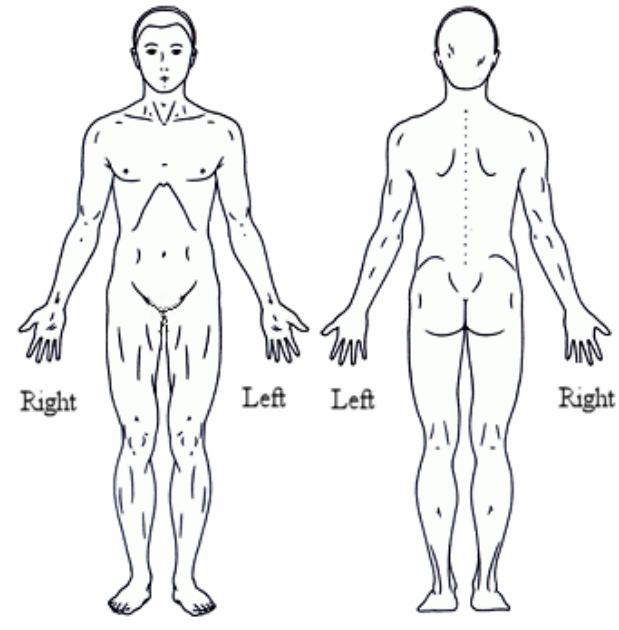
Other doctors seen for this condition _____

Any home remedies? _____

Please circle where you are at: 0 1 2 3 4 5 6 7 8 9 10

("0" is no complaint/pain and "10" is worst possible complaint/pain)

Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Other symptoms:
Please mark any of the following conditions or symptoms that you have now or have experienced:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for this condition? _____
What Medications are you taking? _____ _____
How long?_____ Have you had surgery?_____
What?_____ When?_____
Any drug or surgical side effects that you experienced? _____
Females Only – Date last menstrual cycle began _____ Are you Pregnant? Yes or No

Signature_____**Date**_____

Informed Consent for Chiropractic Treatment and Cancellation

Chiropractic manipulation involves placing hands on areas of the body and looking for areas that may not be moving well, then delivering a small thrust to that area. Sometimes you may hear a noise that is described as a "pop", similar to what you hear when you crack your knuckles.

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments and manipulations are required to advise patients that there are some risks associated with such treatment, but not limited to the conditions listed in this document. In particular you should note: a) while rare, some patients have experienced muscle strain, ligament sprain and rib fractures from spinal adjustments or manipulation; b) there have been reported cases of injury to the vertebral artery (blood vessel in the neck) following adjustment or manipulation of the neck (cervical spine). Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment. The possibility of such injuries resulting from neck spinal adjustment or manipulation are extremely rare; and c) there have been rare reported cases of disc injuries following neck or low back spinal adjustment or manipulation. However, scientific study has not supported that such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with other treatments, medications and procedures given for the same symptoms.

At anytime during your course of treatment, you may withdraw your consent. Also if you have any questions at any point, please feel free to ask us and we will answer your questions to the best of our ability. At the end of this session, we will give you a signed copy of this document for your records.

Chiropractic treatment, including spinal adjustment or manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years. These reports and studies have demonstrated chiropractic treatment to be effective for spinal pains, headaches and other similar symptoms. Chiropractic care may contribute to your overall well being. I cannot guarantee that you will receive any benefit from treatment however; you may get better, get worse or stay the same. Some examples of what I mean by "getting worse" may include: a transient (short lived) increase in symptoms, local muscle discomfort, headache or fatigue. These are common findings and should subside after 24 hours. If you do experience any of these symptoms, please let me know on the next visit or call the office.

A cancellation fee of $40 will be applied to all missed or cancelled appointments within 24 hours of your scheduled appointment.

If you chose not to have chiropractic care, your condition may improve but take longer than with care, or it may get worse. There are other therapies that may treat your condition, such as, medicine, physical therapy and massage therapy. Again each of these also has risks and benefits.

Patient Name: _____ (please print name)

Signature of patient: _____Date: _____