**Conestogo Chiropractic ◈ 1858 Sawmill Rd., ◈ Conestogo, ON N0B 1N0**

Confidential Patient History Form

Name: Date:

Address:

City: Province: Postal Code:

Home Telephone Number: Date of Birth (DD/MM/Y): Age:

Marital Status:  Spouses Name:  Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Occupation:

Employer:  Work Phone:

Who referred you to our office?

**Are you here as a result of:**

Recent motor vehicle accident? Yes No

Work related injury/accident? Yes No

**Prior Chiropractic Care:**

Name: Telephone:

X-Rays Taken? Yes No Date:

Results: Excellent Good Fair Poor

Date of Last Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Health Condition:**

Area of Main Problem:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it getting Better? Worse? Staying the same? Comes and Goes?

Have you had this before? Yes No If Yes, When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had treatment for this or a previous episode? Yes No

If Yes, Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What aggravates your problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What alleviates it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the problem Constant? Intermittent?

Place an X on the grade to indicate the severity of your pain:

Least 1 2 3 4 5 6 7 8 9 10 Worst

Does any member of your family suffer from the same condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Conestogo Chiropractic Patient: Date:**

***Past Health History***

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia

□ Broken Bones □ Back Surgery □ None □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous: Childhood Traumas □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sports Injuries □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Motor Vehicle Accidents □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Injuries □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization (other than above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Family Health History***

Name of Family Physician: Date of Last Physical: \_\_\_\_\_\_\_\_\_\_

Medications: Vitamins: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any health issues that are present in your family:

Parents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care. **Check any of the following you have had in the past six months:**

**Nervous System**

□Nervous

**Gastro-Intestinal**

□Poor / Excessive Appetite

□Excessive Thirst

□Frequent Nausea

□Vomiting

□Diarrhea

□Constipation

□Hemorrhoids

□Liver Problems

□Gall Bladder Problems

□Weight Trouble

□Abdominal Cramps

**Male / Female**

□Menstrual Irregularity

□Menstrual Cramping

□Vaginal Pain / Infections

□Breast Pain / Lumps

□Prostate / Sexual Dysfunction

**Genito-Urinary**

□Bladder Trouble

□Painful / Excessive Urination

□Discoloured Urine

**General**

□Fatigue

□Allergies

□Loss of Sleep

□Fever

□Headaches

**C-V-R**

□Chest Pain

□Short Breath

□Blood Pressure Problems

□Irregular Heartbeat

□Heart Problems

□Lung Problems/Congestion

□Varicose Veins

□Ankle Swelling

□Stroke

**EENT**

□Vision Problems

□Dental Problems

□Sore Throat

□Ear Aches

□Hearing Difficulty

□Stuffed Nose

□Numbness

□Paralysis

□Dizziness

□Forgetfulness

□Confusion / Depression

□Fainting

□Convulsions

□Cold / Tingling Extremities

□Stress

**Musculo-Skeletal**

□Low Back Pain

□Gas/Bloating After Meals

□Pain Between Shoulders

□Heartburn

□Neck Pain

□Black/Bloody Stool

□Arm Pain

□Colitis

□Joint Pain/Stiffness

□Walking Problems

□Difficult Chewing/Clicking Jaw

□General Stiffness

**Conestogo Chiropractic Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Lifestyle Stress Levels**

□ High

□ Moderate

□ Very Little

**Check any of the following diseases you have had:**

□ Pneumonia

□ Mumps

□ Influenza

□ Rheumatic Fever

□ Small Pox

□ Pleurisy

□ Polio

□ Chicken Pox

□ Arthritis

□ Tuberculosis

□ Diabetes

□ Epilepsy

□ Whooping Cough

□ Cancer

□ Mental Disorder

□ Anemia

□ Heart Disease

□ Lumbago

□Measles

□ Thyroid

□ Eczema

**e following diseases you have had:**

□ Pneumonia

□ Mumps

□ Influenza

□ Rheumatic Fever

□ Small Pox

□ Pleurisy

□ Polio

□ Chicken Pox

□ Arthritis

□ Tuberculosis

□ Diabetes

□ Epilepsy

□ Whooping Cough

□ Cancer

□ Mental Disorder

**Females Only**

When was your last period?

Are you pregnant?

□Yes □ No □Not Sure

*Please outline on the diagram the area of your discomfort and any radiation of pain.*

**Intake**

□Coffee



□ Tea

□ Alcohol

□ Cigarettes

□ White Sugar

**Satisfaction with Diet**

□ Highly Satisfied

□ Dissatisfied

□ Highly Dissatisfied

**Do you have a regular**

**exercise program?**

□ Yes

□ No

**Please Read Carefully:**

Doctors of chiropractic who use manual therapy techniques 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 may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques; b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustments is extremely remote; c) There are 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 multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, 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 adjustments) 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Parent/Guardian Signature Date Day/ Month/ Year**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor Signature Date Day/ Month/ Year**