Your Confidential Health Profile

Personal Information **Date:_____**

Name:_____ Age: _____Birth Date (dd/mm/yyyy):_____

How do you wish to be addressed in our office? _____ Gender Identity ☐Male ☐Female

Address: _____

City/Province/Postal Code_____

Home Phone: _____ Work Phone: _____Mobile Phone:_____

E-mail Address (optional)*: _____ Alberta Health Care #_____

Occupation: _____ Hobbies:_____

☐Single ☐Married ☐Divorced ☐Widowed Spouse or Partner's Name:_____

Children's Names & Ages: _____

Previous Chiropractor: _____ Last Visit: _____ Concern:_____

Who referred you to our office? _____ or ☐ internet ☐ phonebook ☐ location other _____

Is this visit related to a WCB or motor vehicle insurance claim? ☐ yes ☐ no If yes, what is the claim #: _____

Do you have extended health care benefits/private health insurance that cover chiropractic care? ☐ Yes ☐ No

Please mark an "X" where you believe your health is and an "O" where you would like to be.

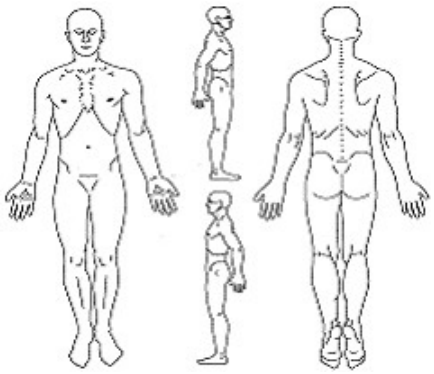
0-59 Very Challenged	60-69 Challenged	70-79 Transition	80-89 Good	90-100 Excellent

Current Health Profile

Health Concerns: List according to their severity:	**Severity:** 1= mild 10= worst	**When did this episode start?**	**If you've had this condition before, when?**	**Are symptoms constant or intermittent?**
1._____	___	_____	_____	_____
2._____	___	_____	_____	_____
3._____	___	_____	_____	_____
4._____	___	_____	_____	_____

Using the appropriate letter from the legend below, please mark any and all areas where you feel pain, numbness, spasm, tenderness or any other sensation that is unusual or abnormal:

Aching – AA
Burning – BB
Cramps – CC
Dull – DD
Muscle Spasm – MM
Numbness – NN
Pins & Needles – PN
Sharp - SP
Shooting - SH
Stabbing – SB
Stiffness – ST
Swelling - SW
Throbbing - TT



Please briefly describe your chief concern, including what you believe caused it to occur: _____
_____

_____

Does the pain travel/radiate anywhere? ☐No ☐Yes - please describe: _____

When did the problem first start? _____

Since the problem started, is it: ☐About the same ☐Getting Better ☐Getting Worse

What makes it worse?_____

What have you done that has helped you feel better? _____

What have you done for it that was of NO help?_____

Is this condition interfering with your: ☐Work ☐Sleep ☐Exercise ☐Hobbies ☐Positive Mental Attitude, ☐Other: _____

Other Health Care Professionals seen for this condition: _____

Treatment and Results:_____

_____

Were x-rays taken? ☐No ☐Yes Area of body:_____ Date: _____

General Health Profile

What are your health objectives?_____

Name of the last doctor who put you on a health development program? _____

Were you able to stay on the program? _____ How long?_____

What were your results? _____Were they permanent?_____

Are you healthier today than you were 5 years ago? _____

If so, what did you do to improve your health? _____

If not, why do you think your health declined? _____

Will you be healthier 5 years from now than you are today? _____

If so, what are you planning to do to improve your health? If not, what could you do to improve your health rather than have it continue to decline? _____

Why do you want to improve your health? _____

_____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

☐Neck pain	☐Pins and needles in arms	☐Low Back Pain	☐Allergies
☐ Headaches	☐Numbness in fingers	☐Pins and needles in legs	☐Asthma
☐ Migraine Headaches	☐Shoulder Pain	☐Numbness in toes	☐Loss of taste
☐Dizziness	☐Mid back Pain	☐Loss of balance	☐Sinus Trouble
☐Fainting	☐Chest Pain	☐Urinary Problem	☐Fatigue
☐Loss of Concentration	☐Heartburn	☐Kidney Problem	☐Cold Sweats
☐Ear Problems	☐Difficulty Breathing	☐Stomach Upset	☐Hot Flashes
☐ Vision Problems	☐Sleeping problems	☐Constipation	☐Depression
☐Nervousness	☐Cold Hands	☐Diarrhea	☐Irritability
☐Tension	☐Cold Feet	☐Irritable Bowel	☐Mood Swings

Women Only: ☐Menstrual Pain ☐PMS Are you pregnant? ☐Yes ☐No

Family Health Profile

Please list any health conditions or concerns that your immediate family may have:

Mother: _____Father:_____

Brothers/Sisters:_____

Children:_____ Spouse: _____

Stress Profile

Chronic stress is the cause of the majority of health problems. Please review each of these common stresses and circle when you experienced it in your life. Use P for Past and C for Current. Your answers will help enable us to determine which factors have contributed to your present health concerns.

Physical Stress:

(P= past, C= current) **Explanation:**

1. Forceps, suction extraction, or caesarean delivery P C _____
2. Accidents (auto, work related, falls or other) P C_____
3. Surgical operations P C_____
4. Strains, sprains, and/or broken bones P C_____
5. Poor posture (excessive computer work, sitting, driving) P C_____
6. Poor sleeping habits P C_____
7. Repetitive movements P C_____
8. Sports injuries P C_____
9. Heavy lifting and/or bending P C_____
10. Overweight P C_____
11. Lack of exercise P C_____

Chemical Stress:

1. Take prescription or over-the-counter medication P C _____
2. Consume alcohol P C_____
3. Consume caffeine (coffee, tea, pop) P C_____
4. Use tobacco products P C_____
5. Use artificial sweeteners (aspartame, sucralose) P C_____
6. Poor diet (fast food, white flour, white sugar) P C_____
7. Environmental pollution P C_____
8. Overweight P C_____

Emotional Stress:

1. Divorce of parents or spouse P C _____
2. Death of a loved one P C_____
3. Serious illness (self or a loved one) P C_____
4. Financial concerns P C_____
5. Procrastination P C_____
6. Worry and/or fear P C_____
7. Work environment P C_____
8. Relationships/Family P C_____
9. Anger by you or at you P C_____
10. Low self-esteem P C_____

*email address is used for receipts and appointment reminders if requested.

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION 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, 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:

- **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.
- **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.

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 _____ Date: _____ 20 _____

_____ _____

Name (please Print) Signature of Chiropractor

_____

Signature of Patient (or legal guardian)