# Total Body Health
# Welcomes You!

Name: ____________________________________________

Date of birth: ________________ M ___ F ____ Marital Status _____ No. Of children ____

Mailing address: ______________________________ Postal Code: __________

Home Phone: ________ Work Phone: __________ Cell Phone #: __________________

Email Address: ____________________ CareCard Health #: __________________

Employer: ______________________ Occupation: ______________________

Referred by: ____________________________________________

Is this related to: ICBC ____ WCB_____ DVA ___ Claim number: __________________

In case of emergency, please list the name/number of a friend or relative: ______________

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**HABITS, DRUGS, and VITAMINS (describe with amounts):**

Sleep: Arise: _____ Retire: _____ Vacations: _________ Exercise: ______________

Alcohol ______________ Coffee/Tea __________________ Cigarettes ______________

Diet ______________ Are you taking any nutritional supplements? __ __________________

Are you currently taking any medication? _______ Describe: ______________________

____________________________________________

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What is your reason for consulting the doctor? ______________________________

______________________ How long have you had this condition? ____________

What important activity have you been unable to do because of your condition? ____________

Have you had this or similar conditions in the past? ______________________

Is this problem getting worse? _____ _ Constant? ______ Worse in the morning? ____ Evening? _____

Is this interfering with work? _____ Sleep? _______ Exercise? ______ Other? ____________

Have you seen other chiropractors/doctors for this condition? ______________________

Are there any other problems that you are currently experiencing? ______________________

____________________________________________

Date of your last physical exam? ______________ Dr.: ______________________

Have you ever been hospitalized? ______________________________

Are you allergic to any foods, drugs, chemicals etc.? ______________________

Remarks and any additional information: ______________________________

Do you use birth control? ______________ When was the date of your last period? ____________

Please circle the appropriate letter for any of the following symptoms which you now have or have had previously.

**C = Constant    F = Frequent    O = Occasional**

**NEUROLOGICAL**

C F O numbness
C F O allergy
C F O dizziness
C F O dropping things
C F O double vision
C F O fainting
C F O fevers
C F O headaches
C F O loss of sleep
C F O weight loss
C F O weight gain
C F O nausea
C F O neuralgia
C F O sweats
C F O tremors
C F O co-ordination off

**MUSCLE AND JOINT**

C F O arthritis
C F O bursitis
C F O low back pain
C F O pain btw shoulders
C F O neck pain
C F O neck stiffness
C F O sciatica

**RESPIRATORY**

C F O chest pain
C F O chronic cough
C F O difficulty breathing
C F O spitting blood
C F O throat phlegm
C F O wheezing
C F O asthma

**EYES, EARS, NOSE, & THROAT**

C F O colds
C F O deafness
C F O dental problems
C F O ear aches
C F O ear noises
C F O sinus infections
C F O enlarged glands
C F O sore throat
C F O tonsilitis
C F O eye pain
C F O failing vision
C F O gum trouble
C F O hay fever
C F O hoarseness
C F O nasal obstruction
C F O nose bleeds

**CARDIO-VASCULAR**

C F O rapid heart beat
C F O slow heart beat
C F O swelling of ankles
C F O hardening of arteries
C F O high blood pressure
C F O low blood pressure
C F O pain over heart
C F O poor circulation

**SKIN**

C F O bruise easily
C F O dryness
C F O hives or allergy
C F O itching
C F O skin rash
C F O varicose veins

**GASTROINTESTINAL**

C F O excessive hunger
C F O burping or gas
C F O liver trouble
C F O colon trouble
C F O constipation
C F O diarrhea
C F O difficult digestion
C F O abdomen distended
C F O stomach pain
C F O gall bladder trouble
C F O hemorrhoids
C F O poor appetite
C F O nausea
C F O vomiting

**GENITO-URINARY**

C F O blood in urine
C F O frequent urination
C F O kidney infection
C F O painful urination
C F O prostrate trouble
C F O smell of urine

**FOR WOMEN ONLY**

C F O cramps
C F O heavy flow
C F O light flow
C F O irregular cycle
C F O painful cycle
C F O discharge
C F O sore breasts

Menopausal: Yes No

Last menstruation date:

______________________________

Pregnant: Yes No

## HISTORY:

Previous Surgeries (When and where on your body):

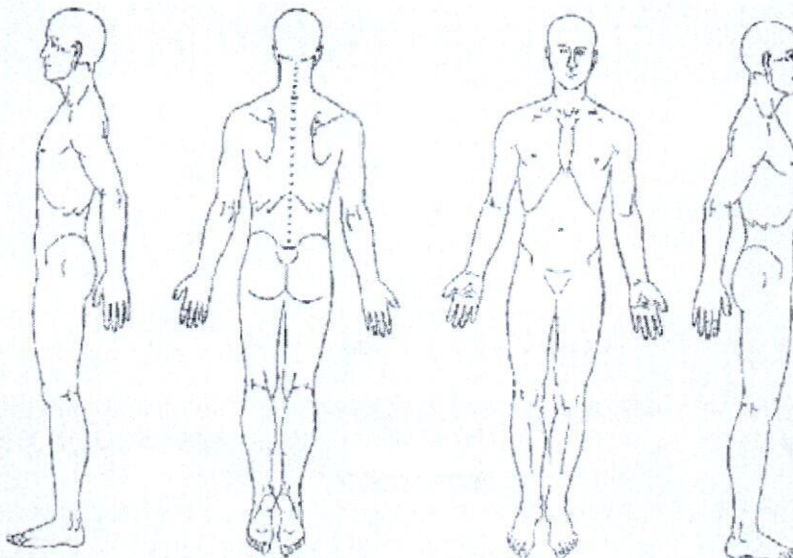
Car Accidents (When and Briefly describe):

Falls, Tumbles, Concussions, Broken Bones:

Family History (Mother, Father and Siblings Health):

USE THE LETTERS BELOW TO INDICATE THE TYPE & LOCATION OF YOUR SENSATIONS RIGHT NOW

KEY: A= Ache B= Burning D= Dull Pain N= Numbness
P= Pins & Needles S= Stabbing O= Other



# 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.

**I acknowledge it is my responsibility to pay the fees as set out, for the Chiropractic Services at the time services are rendered. First visit is $150 and Subsequent Visits are $70. Extended treatments if necessary are charged accordingly. 24hrs notice is required to cancel an appointment. There will be a cancellation fee of 80% of the appointment fee for any missed appointments or late cancellations.**

***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.

______________________________
Name (Please Print)

______________________________ Date: ____________ 20____
Signature of patient (or legal guardian)

______________________________ Date: ____________ 20____
Signature of Chiropractor