Patient Introduction

Date:_____

Name: _____
First Middle Last

Address: _____

_____

_____ PC: _____

Telephone: Home:_____ Cell: _____

Work: _____

Emergency contact name and #:_____

Alberta Health Care Number: _____

Email: _____

*If you would like to subscribe to our appointment reminders, newsletters, educational and lifestyle information

Gender: Male _____ Female _____

Birth Date: Month: _____ Day: _____ Year: _____ Age: _____

Occupation: _____ Employer: _____

Marital Status: _____ Name of Spouse: _____

Ages of Children: _____

Who may we thank for referring you to our office? _____

Consultation History

Your Name: _____

☐ **Check here if you have no complaints and are here for Wellness Care. Then skip to next page.**

Is this a work related injury? **Yes** **No**

If this is related to a recent motor vehicle accident, please fill out the MVA Questionnaire instead.

Your Main Complaint: _____

How long has this been a problem? _____

How did it start? _____

Have you had this problem before? **Yes** **No**

How would you describe it? (Circle all that apply)

Shooting **Stabbing** **Throbbing** **Aching** **Tightness** **Other**:_____

How significant is the issue? On the following scale, place a "W" where you would rank this at its Worst, and place a "B" where you would rank it when it's at its Best.

No Pain/No Concern Worst I Can Imagine

0 1 2 3 4 5 6 7 8 9 10

|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|

Before you began to suffer with this problem, was there an earlier accident, injury that could have brought this about or be related to it? _____

What do you do that makes this problem worse? _____

_____

What gives you some temporary relief?_____

What have you tried to do to get rid of this problem that DID NOT work? _____

_____

Have you become discouraged about handling this problem? **Yes** **No**

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

What is the pattern of this problem? (Circle One) **Constant** **Intermittent** **Occasional** **Cyclical**

What effects does this have on any body functions? _____

_____

Any other complaints? (Please note as many factors from the questions on page 1 as they apply)

_____

_____

_____

Are you on any type of medication? **Yes** **No** Please list all:_____

_____

Please note any surgeries that you have had along with their dates: _____

_____

Have you ever been involved in an auto accident before? **Yes** **No**
Date(s) of accident: _____

Any difficulties from this? _____

Please list any serious injuries or illnesses in your past (including factures and hospitalizations):

_____

_____

Please list any family history of cardiovascular disease, heart disease or cancers etc….

_____

Females: Are you pregnant? _____

Age of your mattress? _____ Is it comfortable? _____

Do you sleep on your: side stomach back

Have you had a recent, sudden loss in weight? _____

Is anything causing excessive stress and tension? _____

Habits: please circle heavy(H), medium(M), light(L) or none(N)

Alcohol H M L N	Tobacco H M L N
Coffee H M L N	Exercise H M L N

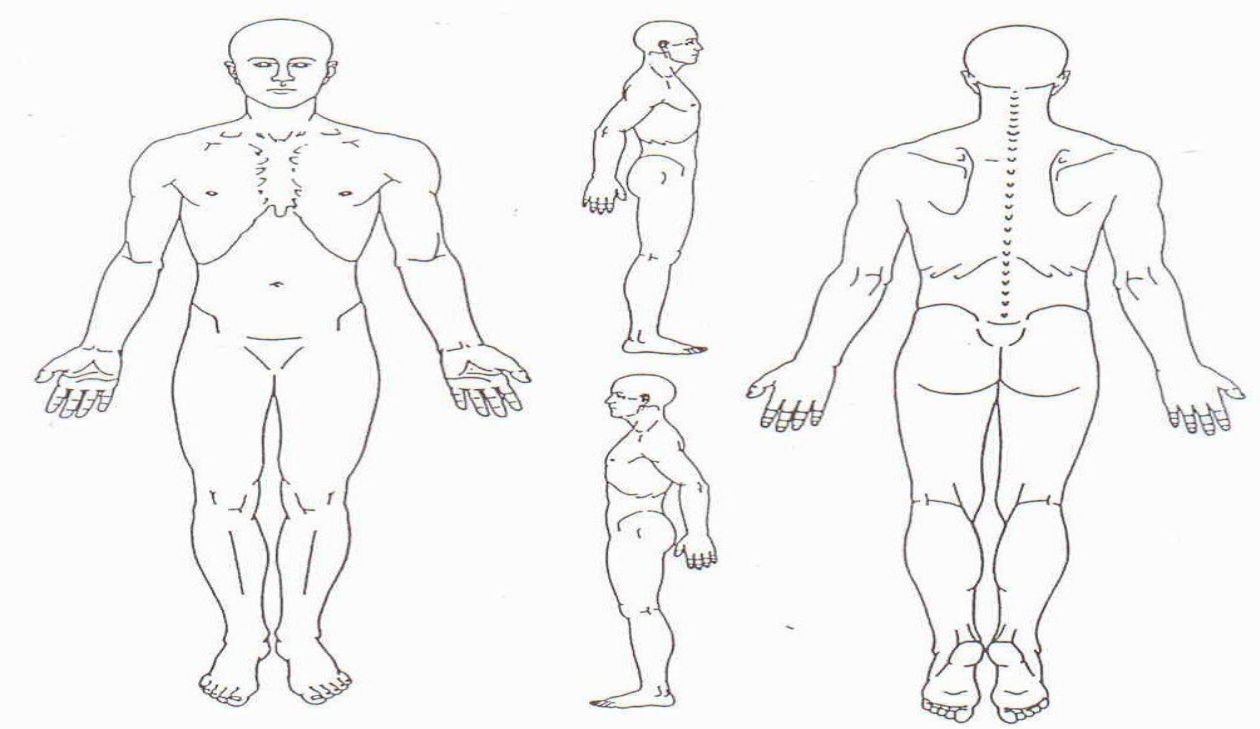
Previous Chiropractor: _____

Last visit to this Chiropractor: _____ Reason for leaving: _____

Is there any other information you would like us to know? _____

_____

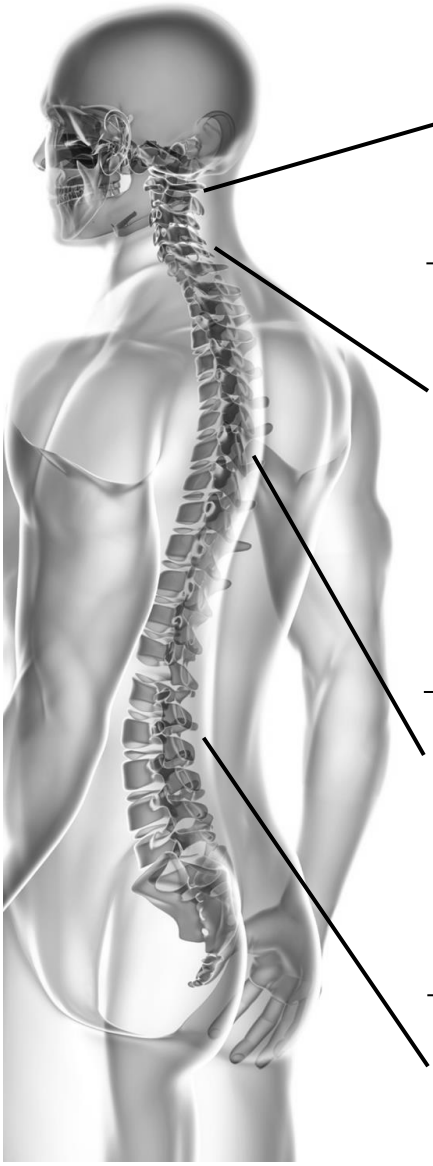
Using this diagram below, please indicate the location of the complaint you are experiencing right now:
If the pain radiates away from the area of complaint please also mark it on the diagram:



The Nervous System (Brain, Spinal Cord and Nerves) sends signals out from different levels of your spine to control specific areas of your body. This system controls everything in your body.

Interference known as a **Subluxation** can cause problems at specific levels of the spine, causing different symptoms.

Are you currently experiencing any of the following issues? **Check all that apply.**



Upper Neck

These Nerves Control:

- Head, Face

☐ – Headaches
☐ – Dizziness, Lightheadedness
☐ – Ringing in your Ears
☐ – Face Pain
☐ – Vision Problems, such as Floaters
☐ – Frequent Sighing

Lower Neck

These Nerves Control:

- Thyroid Gland
- Vocal Chords
- Shoulders
- Arms, Hands

☐ – Neck/Shoulder Tension
☐ – Hands go Tingly/Numb
☐ – Fingers Sore/Tight/Swollen
☐ – Arm/Fingers Give Out Easily
☐ – Anxiety/Depression
☐ – Weight Gain/Loss
☐ – Hormonal Issues; PMS, Hot Flashes
☐ – Difficulty Swallowing
☐ – Having to Clear Your Throat in Morning
☐ – Lose Pitch When Talking/Singing

Between the Shoulder Blades

These Nerves Control:

- Heart
- Lung
- Stomach

☐ – Heart Palpitations
☐ – Asthma/Shortness of Breath
☐ – Chest Pressure/Pain
☐ – Acid Reflux/GERD
☐ – Ulcers
☐ – Excessive Burping

Low Back

These Nerves Control:

- Bowel
- Bladder
- Sexual Function
- Back, Legs, Feet

☐ – Constipation/Diarrhea/Rectal Bleeding
☐ – Gas/Bloating
☐ – Sexual Difficulties/Fertility Problems
☐ – Urinary Problems; Dribbling
☐ – Crohn's/Ulcerative Colitis/IBS
☐ – Cramping in Legs/Calves/Feet at night
☐ – Knee Pain
☐ – Cold Feet
☐ – Numbness in Feet/Legs

Systems Review

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hand or feet	Gallbladder/jaundice
	Varicose veins	Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders swollen joints	Birth control pills
Enlarged glands	Spinal curvature	Miscarriages
	Arthritis	Complications with pregnancy
	Fractures	Pregnant? Y / N Week?
		Other:

MEDIA RELEASE CONSENT

Purpose of Consent: By signing this form, you are consenting to allow **ELEVATE LIFE CHIROPRACTIC CLINIC** and any associated staff members to use and distribute your photo along with your patient testimonial. To use and disclose the information you provided in your video consent. Also acknowledge that your testimonial may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to us. Please understand that revocation of this Release will not affect any action **ELEVATE LIFE CHIROPRACTIC CLINIC** or his/her staff took in reliance on this Release before receiving your revocation.

I hereby grant permission to allow **ELEVATE LIFE CHIROPRACTIC CLINIC** to use the photograph of me shown below in conjunction with my patient testimonial. I hereby agree and acknowledge that my photo will be released to the public via public relation efforts of **ELEVATE LIFE CHIROPRACTIC CLINIC** I further acknowledge and agree that my photo, video, or testimonial may be used by the media.

I waive the right of prior approval and hereby release **ELEVATE LIFE CHIROPRACTIC CLINIC** from any and all claims for damages of any kind based on the use of my photo, video or information contained in my testimonial.

By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

_____

Signature and/or Legal Guardian Date

_____

Print Name

I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. _____ (Initials)

I further understand that interest of 2% per month calculated monthly (24% per year compounded monthly) would be charged to any unpaid balance. I agree to pay this interest on any unpaid balance. I further agree to pay for any charges or fees (collection charges or legal fees) incurred in the collection of this account, should that become necessary. _____ (Initials)

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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 <u>NOT</u> 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____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

Thank You!