

PATIENT INTRODUCTION FORM

LAST name: _____ Marital Status S M W D
First Initial

Address: _____ Spouse's name: _____

City: _____ Postal Code: _____ Number of children: _____

Telephone: H _____ W _____ C _____ Email _____

Sex: Male ___ Female ___ Date of Birth: M _____ D _____ Y _____ Age: _____

Family Physician: _____ Physician telephone number: _____

Occupation: _____ Referred by: _____

B.C. CARECARD #: _____ Any private Insurance: Y N

Do you have reason to believe that you may be pregnant? No Yes Due date: _____

Is this a claim from: ICBC _____ WCB _____ Claim #: _____ Date of Accident _____

End date of claim: _____ Adjuster's name: _____ Telephone #: _____

REASON FOR VISIT: _____

If you are experiencing pain, is it: Shooting Sharp Stabbing Throbbing Achy Burning Dull (Please circle)

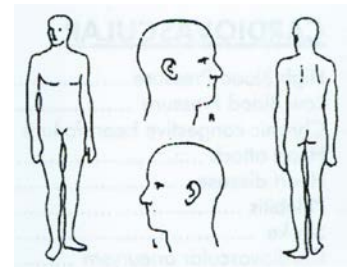
ARE YOU EXPERIENCING NUMBNESS OR TINGLING? Yes No

How would you classify your pain level? Slight Moderate Severe (Please circle)

When did it start: _____

What relieves the condition: _____

What aggravates the condition: _____



Is the condition getting worse? Yes No Constant Comes and goes (Please circle) mark area

Have you seen a: Chiropractor Physiotherapist Massage therapist Acupuncturist Physician Other (Please circle)

For what condition and when: _____

Have you had any surgery? Yes No For what part and when? _____

Are you presently taking medication? Yes No If yes, please give name and what it's for: _____

In consideration of your practitioner and fellow patients, **24 hour notice of change of appointment or cancellation must be given or a fee will be charged. Patient is responsible for payment of services if medical insurance is not valid.** _____ Initial please.

Signature: _____ Date: _____

Please indicate conditions presently causing problems as well as conditions which were a problem in the past.

BABIES & CHILDREN

Present Past

Birth trauma	<input type="checkbox"/>	<input type="checkbox"/>
Feeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Colic	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Developmental delays	<input type="checkbox"/>	<input type="checkbox"/>
Behavioural	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity / ADD/ ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Learning disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Eye motor problems	<input type="checkbox"/>	<input type="checkbox"/>
PDD/autism	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

Present Past

Chronic Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

Present Past

High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chronic congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker / other device	<input type="checkbox"/>	<input type="checkbox"/>
Coldness in extremities	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL

Present Past

Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Pain or discomfort before eating	<input type="checkbox"/>	<input type="checkbox"/>
Pain or discomfort after eating	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder (anorexia/bulimia)	<input type="checkbox"/>	<input type="checkbox"/>

HEAD/NECK/BACK

Present Past

Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Dental Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontics	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Problems		
pain/clicking/locking	<input type="checkbox"/>	<input type="checkbox"/>
Whiplash	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Facial Pain	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>
Other neurological conditions	<input type="checkbox"/>	<input type="checkbox"/>
List _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

OTHER CONDITIONS

HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes		
Onset Date: _____		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Susceptible to colds / infections	<input type="checkbox"/>	<input type="checkbox"/>
High Stress Levels	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia / Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness and/or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Infectious conditions	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>
STD's	<input type="checkbox"/>	<input type="checkbox"/>
Tumors / Cysts	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
IUD	<input type="checkbox"/>	<input type="checkbox"/>
Gynecological concerns (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment **FORM L**

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____
(please print)

Name: _____
(please print)