DISCOVERY - HEALTH DANGERS

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ Postal Code: _____

Home #: _____ Age: _____ Birth date: (M) (D) (Y) _____

Workplace: _____ Office #: _____ Occupation: _____

Referred by: _____ ❍ Single ❍ Widowed ❍ Married (SPOUSE'S NAME): _____

# of Children: and their ages: _____

PREVIOUS TRAUMAS

MOTORIZED VEHICLE ACCIDENTS

Year: _____ Injuries: _____
Year: _____ Injuries: _____
Year: _____ Injuries: _____

❍ High Speed Collisions >40km/h? ❍ Vehicles unrepairable?
❍ Whiplash injury? ❍ Un-belted accident?

SPORTS & RECREATION:

Sports injuries: _____
_____

Participation in High Impact Activities:

❍ Hockey ❍ Wrestling ❍ Basketball
❍ Running ❍ Mountain bike ❍ Climbing
❍ Football ❍ Gymnastics ❍ _____

FALLS

Falls from heights _____
Falls down stairs _____
Other falls _____
Broken bones _____
Childhood falls _____
_____
_____

Falls from:

❍ Trees ❍ Roof ❍ Play structure ❍ Bicycle

OCCUPATIONAL STRESSES

Occupation _____
Tasks _____
Work injuries _____
_____
Home injuries _____
My job requires:

❍ Heavy Lifting ❍ Awkward positions
❍ Repetitive stresses ❍ Sitting long periods

POSTURES & HABITS

❍ Sitting >6 hours/day ❍ Stomach sleeper
❍ Head forward posture

BIRTH TRAUMA was your delivery

❍ Difficult ❍ Forceps ❍ C-section
❍ Epidural ❍ Suction ❍ Resuscitation

DISCOVERY - HEALTH DANGERS

WHAT IS YOUR PRESENT HEALTH CONCERN?

_____

_____

How long have you had this condition?

_____

Have you had a similar condition in the past?

_____

What activities aggravate your condition?

_____

What relieves your condition?

_____

Are you getting pain or numbness in your arms or legs?

_____

Is your condition getting progressively worse?

❍ Yes ❍ No ❍ It's constant ❍ It comes and goes

Pains are: ❍ Sharp ❍ Dull ❍ Burning

❍ Tightness ❍ Throbbing

Pain severity (mark on the line, 0 no pain; 10 most severe)

0 10

How is this condition interfering with your life?

❍ Work ❍ Daily Routine ❍ _____

Other doctors) who treated this condition:

_____

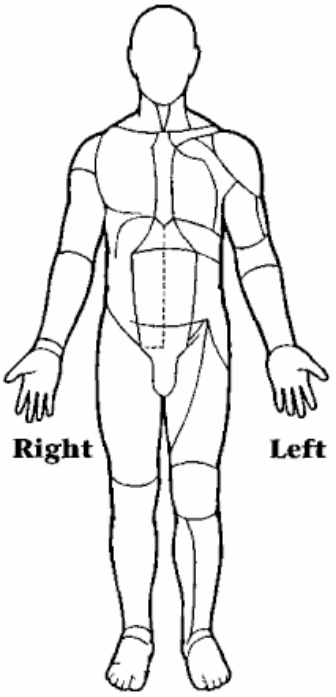
FAMILY HEALTH PROBLEMS?

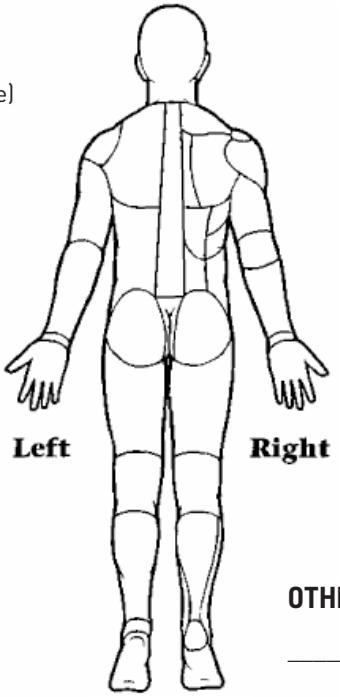
_____

_____

_____

_____





MARK WITH AN X ON THE DIAGRAM ANY PAST OR PRESENT PAIN OR PROBLEMS AND CHECK THE APPROPRIATE CIRCLE BELOW:

❍ Headaches ❍ Facial pain

❍ Vision problems ❍ Hearing problems

❍ Shoulder: Pain / Numbness / Tingling (circle)

❍ Arm: Pain / Numbness / Tingling (circle)

❍ Hand: Pain / Numbness / Tingling (circle)

❍ Hip: Pain / Numbness / Tingling (circle)

❍ Knee: Pain / Numbness / Tingling (circle)

❍ Foot: Pain / Numbness / Tingling (circle)

❍ Neck Pain

❍ Upper Back Pain

❍ Middle Back Pain

❍ Low Back Pain

❍ Sacroiliac Pain

OTHER HEALTH PROBLEMS?

_____

_____

_____

_____

DISCOVERY - HEALTH DANGERS

PLEASE CHECK ANY OF THE FOLLOWING SIGNS OF ORGAN MALFUNCTION OR DIS-EASE YOU HAVE EXPERIENCED:

❍ Blurred /failing vision
❍ Deafness /ringing in ears
❍ Earaches
❍ Sore throat /tonsilitis
❍ Thyroid problems
❍ Sinus problems

Cardiovascular system

❍ Chest Pain
❍ Shortness of Breath
❍ Heart Medication
❍ High Blood Pressure Medication
❍ High Cholesterol Medication
❍ Swelling of Legs

Respiratory system

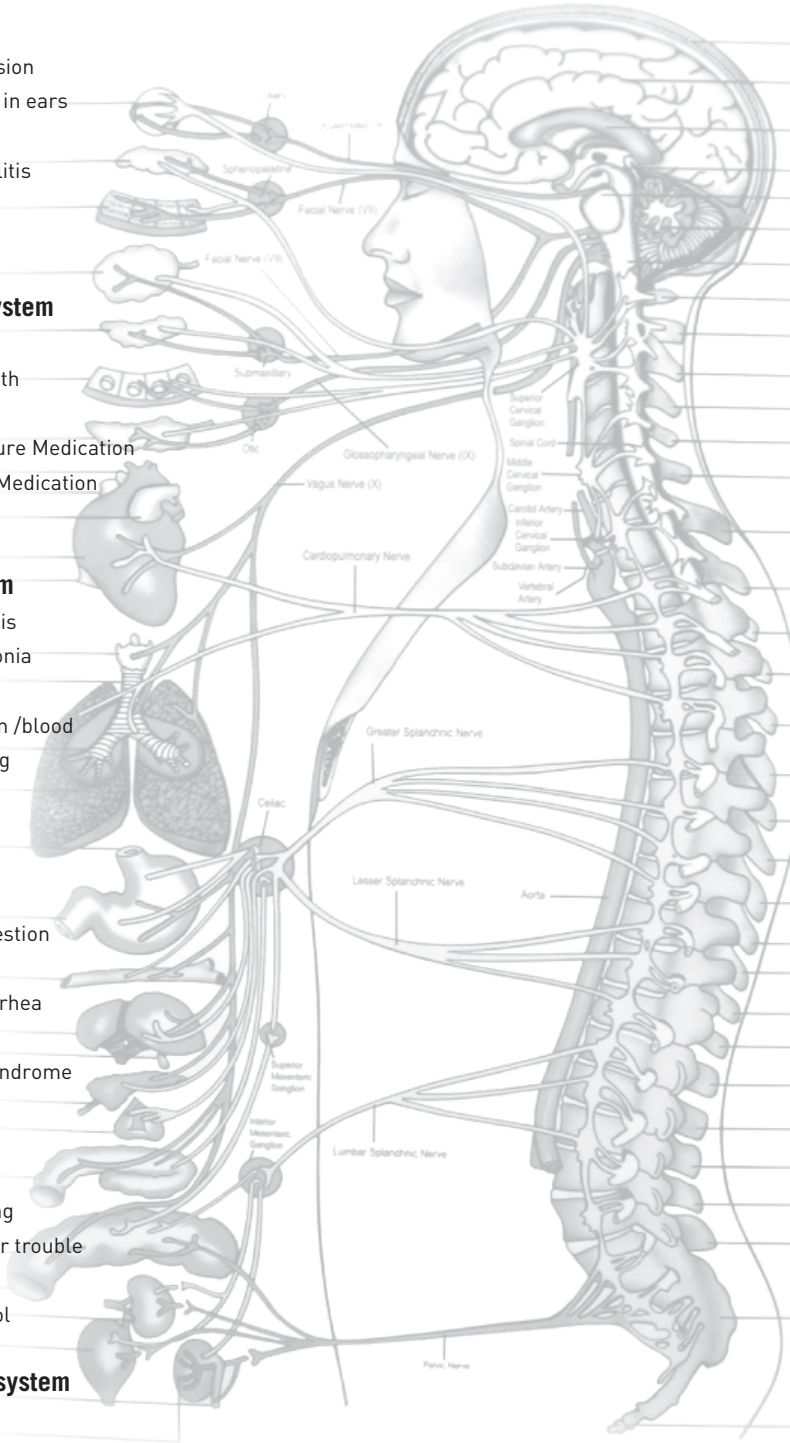
❍ Frequent bronchitis
❍ History of pneumonia
❍ Chronic cough
❍ Spitting up phlegm /blood
❍ Difficulty breathing
❍ Tuberculosis
❍ Pneumonia

Digestive system

❍ Heartburn / indigestion
❍ Stomach Cramps
❍ Constipation /diarrhea
❍ Food Allergy
❍ Irritable Bowel Syndrome
❍ Crohn's Disease
❍ Ulcers
❍ Belching /gas
❍ Nausea or vomiting
❍ Liver /gall bladder trouble
❍ Colon trouble
❍ Black /bloody stool

Musculoskeletal system

❍ Painful Joints
❍ Painful Muscles
❍ Tendinitis
❍ Bursitis
❍ Arthritis



General Symptoms

❍ Fever / chills / sweats
❍ Frequent colds
❍ Fainting / dizziness
❍ Seizures / convulsions

❍ Headaches /migraine
❍ Neck pain /stiffness
❍ Tension across shoulders, L R
❍ Mid-back pain /stiffness
❍ Numbness /tinglining: hands /arms

General Symptoms

❍ Skin problems
❍ Tremors
❍ Loss of balance
❍ Unexplained weight loss/gain
❍ Anemia
❍ Alcoholism
❍ HIV/AIDS
❍ Loss of sleep
❍ Poor memory /concentration
❍ Learning disability
❍ Irritable /nervous /tension
❍ Depression /emotional problems
❍ Decreased energy / fatigue
❍ Tired /lethargic
❍ Autoimmune Disease
❍ Antibiotic Use
❍ Cancer: _____
❍ Allergies / Asthma
❍ Scoliosis / spinal curvature
❍ Low back pain / stiffness
❍ Faulty posture
❍ Painful tailbone
❍ Foot trouble, L R

Females Only

❍ Painful menstruation
❍ Cramps or backaches
❍ Passed menopause
❍ Currently pregnant? ❍ Y ❍ N
❍ Excessive /irregular flow
❍ Abnormal discharge
❍ Miscarriages #_____
❍ Date of last menstrual period: _____

DISCOVERY - HEALTH DANGERS

PERSONAL INFORMATION

How has your condition affected your quality of life? _____

_____

How has your condition affected you emotionally?_____

_____

How has your condition affected your family life and/or relationships? _____

_____

If left uncorrected, how do you see your condition affecting your life over the next 1-5 years? _____

_____

If you are a candidate for spinal reconstruction and if we were having this conversation 12 months from today, what has to happen over that time to make you feel happy with your progress? _____

_____

What is your greatest motivation (other than pain) for seeking out a solution for your condition?
(Mobility, quality of life, family, participation in sports, etc.) _____

_____

_____

Do you believe that this condition can improve? _____

_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I understand that any insurance coverage is an arrangement between the insurance company and myself. I understand that your Chiropractic Clinic will prepare any necessary reports and forms to assist me in submitting a claim to the insurance company. Furthur more, I understand and agree that all services rendered, are charged directly to me and that I am personally responsible for payment.

Our goal is to locate and correct vertebral subluxation, thereby restoring normal function to the spine, and removing any interference to nerve function, and maximizing the transmission of nerve impulses from brain to body. While we often see dramatic improvements in many diseases and conditions by restoring function to the spine and removing nerve interference, Chiropractic is not a treatment of any disease condition.

I understand and I am informed that, as in all health care, in the practice of Chiropractic there are some possible risks to care including, but not limited to, minor strains and sprains, and disc injuries. Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following – there have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes, or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are less than 1 in 5.8 million. Tests with or without X-Rays have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest, most effective forms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor.

I have read the above statements and consent to treatment.

Signature_____ Date _____