taylor creek CHIROPRACTIC

Confidential Health History Form
ADULT

Name:		Cell Phone:
Address:		Home Phone:
City:	Prov:	Work Phone:
Postal Code:	Gender: F / M / O	Birth Date: D/M/Y Age:
Email:		Spouse/Partner Name:
Occupation:		Spouse/Partner Phone:
Business/ Employer:		Spouse Employer:

Emergency Contact Name & Phone:

Health Insurance Company & coverage amount/year:

Name of Family Doctor:	Date of last physical:

First name and age of your kids:

List Exercises - Hobbies - Interests:

Would you like appointment reminders by: ☐ **EMAIL** ☐ **SMS(text)** ☐ **Phone** ☐ **No reminders necessary**

How did you hear about our office? ____________________

Have you had previous Chiropractic care? ☐ No ☐ Yes If yes, when was your last visit: ____________

Indicate your primary symptom: ____________________

Is your symptom due to an accident? ☐ No ☐ Yes Type of Accident: ☐ Auto ☐ Work ☐ Other

When did your symptom begin? ____________________ **Have you had this symptom before?** ☐ No ☐ Yes

What do you think caused your symptom? ____________________

Have you had previous treatment for this symptom? ☐ No ☐ Yes, specify ____________

Have you had X-ray, MRI or other tests for this symptom? ☐ No ☐ Yes, specify: ____________

Does this symptom interfere with your: ☐ work ☐ sleep ☐ personal life ☐ mood ☐ activities ☐ other

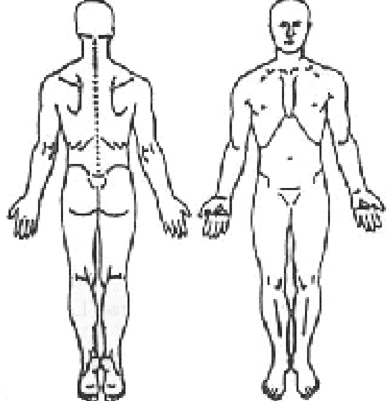
Rate the intensity of your symptom **1 2 3 4 5 6 7 8 9 10**

Least pain **Worse pain**

Is your symptom: ☐ **Constant** ☐ **Occasional** **Worse** ☐ **in the morning** ☐ **at night**

What aggravates your symptom? ____________________

What relieves your symptom? ____________________



Indicate on the diagram (to the right): **S** for **SHARP** Pain **D** for **DULL** pain

T for **TINGLING/NUMBNESS** **B** for **BURNING / THROBBING** **A** for **ACHING** pain

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Please ☑ check the following boxes: "C" for the conditions you are CURRENTLY experiencing and under the "P" for conditions you have had in the PAST ** the *last few rows in italics are for WOMEN only* **

	C | P		C | P		C | P		C | P
Unexplained weight loss	☐|☐	Slurred speech	☐|☐	Poor appetite	☐|☐	Headaches	☐|☐
Unrelenting pain (day or night)	☐|☐	Previous stroke/ TIA	☐	Fever / chills/ sweats	☐|☐	Jaw pain	☐|☐
Loss of bowel/bladder function	☐|☐	Double vision	☐|☐	Frequent colds	☐|☐	Sinus pain	☐|☐
Loss of balance/ feel unstable	☐|☐	Heart palpitations	☐|☐	Anxiety/ depression	☐|☐	Neck pain	☐|☐
Poor concentration or memory	☐|☐	Fainting / dizziness	☐|☐	Heartburn/indigestion	☐|☐	Upper/Mid Back	☐|☐
Ringing in the ears / tinnitus	☐|☐	Angina/ chest pain	☐|☐	Constipation/Diarrhea	☐|☐	Shoulder pain	☐|☐
Spitting up blood/ phlegm	☐|☐	High blood pressure	☐|☐	Irritable bowel	☐|☐	Wrist/hand pain	☐|☐
Difficulty swallowing	☐|☐	Low blood pressure	☐|☐	Nausea / vomiting	☐|☐	Low Back pain	☐|☐
Varicose veins/ phlebitis/clots	☐|☐	Tremors	☐|☐	Asthma	☐|☐	Hip/Groin pain	☐|☐
Blood in stool / urine	☐|☐	Difficulty breathing	☐|☐	Ear infection	☐|☐	Knee pain	☐|☐
Painful urination	☐|☐	Chronic cough	☐|☐	Difficulty sleeping	☐|☐	Ankle/arch pain	☐|☐
Cold/ swollen hands or feet	☐|☐	Bronchitis	☐|☐	Pneumonia	☐|☐	Migraines	☐|☐
Menstrual pain	☐|☐	*Hot flashes*	☐|☐	*Weight gain*	☐|☐	*Weight loss*	☐|☐
Mood swings	☐|☐	*Irregular cycles*	☐|☐	***If Pregnant due date***			

Indicate any other conditions of concern: ____________________

Please check ☑ what applies to you

Prolonged sitting/ desk work	☐	Repetitive lifting	☐	Prolonged standing	☐	Repetitive twisting	☐
Emotional stress	☐	Poor posture	☐	Lack of sleep	☐	Stomach sleep	☐
As a child fell /jumped from a height greater than 4 ft (e.g. play structure)	☐	**As a child** had impacts snowboarding/ skiing/ biking /trampoline etc....	☐	**As a child** played contact sports	☐	**As a child** sustained other traumas	☐
History of concussion	☐	Fractured a bone	☐	Received stitches	☐	Had surgery	☐
Had a work injury	☐	Repetitive type injury	☐	Had a serious fall	☐	Chronic stress	☐
Had a car accident	☐	Went to Emergency	☐	Cancer diagnosis	☐	Have HIV	☐

Describe any major trauma or impact: ____________________

List any diagnosed condition(s): ____________________

List any medication you are currently taking: ____________________

List intake

Coffee ________/ day	Caffeinated drinks:_______/day	Glasses of water:_______/day	Alcohol:______/day ________/week
Cigarettes _______/day	Hours of sleep:________/night	Hours of driving:_______/day	Hours of sitting ________/day

The fee for the New Patient Consultation and examination is 95$. X-ray digital imaging if required is 40$ - 80$.

Signature: ____________________ **Date**: ____________________

Informed Consent to Chiropractic Care

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscles and ligament strains and sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do 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 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 skin irritation/ bruising with the use of some types of instrument or therapy offered by some doctors of chiropractic.

e) Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that association with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.
I consent to the chiropractic treatments offered or recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care in this office. ______

Dated this__________________________day of _______________________________, 20____________

_______________________________   _______________________________

Patient Signature (Legal Guardian)   **Witness of Signature**

_______________________________   _______________________________

Print Name   **Print Name**