

Confidential Patient Information

Welcome to our practice! Please complete all questions. Thank you.

Date: _____

Name: _____ Sex: M ___ F ___ Birth Date _____ Age _____

Address: _____ City: _____ Postal Code: _____

Home : (____) _____ Work Phone: (____) _____ Mobile: (____) _____

Email Address: _____ Occupation: _____

Marital Status (Circle One): M S W D CL Spouses Name: _____

Children's Names and Ages: 1. _____ 2. _____ 3. _____

Do you have extended health insurance? Yes ___ No ___ Name of Company: _____

Name of Insured Member: _____ DOB: _____

Relation to insured member: _____ Policy #: _____ Member ID #: _____

Whom may we thank for referring you? _____

List your Chief complaints in order of priority:

- | | |
|----------|---------------------|
| 1. _____ | For how long? _____ |
| 2. _____ | For how long? _____ |
| 3. _____ | For how long? _____ |

Is this a result of an auto or work injury? AUTO ___ WORK ___ NONE ___

a) If yes, when? _____ b) Details of injury: _____

Family Doctor: _____ Telephone Number: _____

Medications you currently take:

Surgeries you have had in the past:

Patient or Guardian Signature

Date

**Chahal MacAskill Chiropractic
& Wellness Centre**
500 Dundas Street West.
Whitby Ont. L1N 2M9

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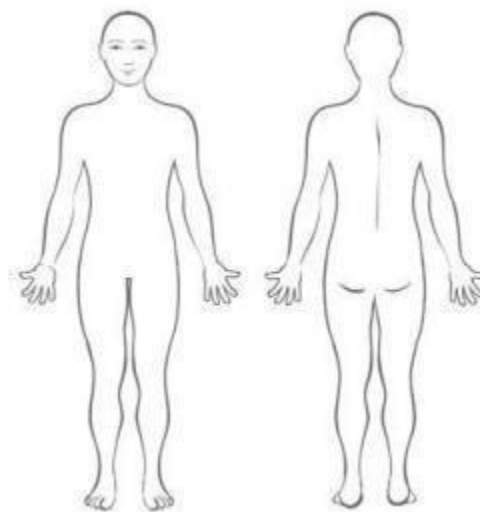
Have you ever been to a chiropractor? Yes, ___ No ___ If yes, When? _____

1. For what condition did you receive treatment? _____
2. Did the treatment give you relief? YES _____ NO _____

Please check any of the following that pertain to your current health status:

- | | |
|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shortness of breath |
|
 | |
| <input type="checkbox"/> Joint Pain/ Stiffness | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Bladder Trouble |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Numbness/ Tingling | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver/Gall Bladder Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fatigue/Loss of Sleep |
|
 | |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Confusion/Depression |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Vision Problems |
|
 | |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | |

Please outline on the diagram the areas of discomfort



Other problems: _____

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Lower Limb Biomechanics/ Circulation:

Varicose Veins Leg/foot Swelling Spider Veins Leg/Foot pain and tiredness

Bunions Hammer Toes Flat Foot High Arch

Hip/knee pain Diabetic Overweight Arthritis

Have you ever worn:

Orthotics: NO YES If yes, what year? _____

Compression Hosiery: NO YES If yes, what year? _____

FEMALES ONLY

When was your last period? _____ Menstrual Problems YES NO

Are you pregnant? YES NO Breast Pain/ lumps? _____

a) If yes, due date: _____

I hereby give my permission to undergo a physical examination which has potential to reenact my pain.

The above information is true and accurate to the best of my knowledge.

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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 the 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 with 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 disc** - Over the course of a lifetime, spinal discs may be 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.

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Dr. Sonam Chahal & Dr. David MacAskill

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- **Stroke** - Blood flows to the brain through the two sets of arteries passing through the neck. These arteries may become weakened or 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 and 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 NOT SIGN THIS FORM UNTIL YOU MEET WITH YOUR 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 proposed to me.

Patient or Guardian Signature

Date: _____ 20 _____

Chiropractor Signature

Date: _____ 20 _____

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