TO THE NEW PATIENT

Outline of Procedure for New Patients

STEP ONE:	All new patients are required to complete a personal health/history questionnaire.
STEP TWO:	Your first consultation with a doctor to discuss your health problems.
STEP THREE:	Diagnostic, chiropractic, orthopedic, and neurological examination procedures to determine if chiropractic is appropriate for your condition.
STEP FOUR:	The doctor will advise you as to the need of additional procedures such as laboratory and x-ray tests, if necessary.
STEP FIVE:	If your case requires immediate attention, emergency first aid will be administered.
STEP SIX:	You will be advised as to a time you can return for your "Report of Findings" when your doctor will inform you as to your examination results and whether or not your case has been accepted. You will also be advised concerning financial arrangements and insurance coverage as appropriate.
STEP SEVEN:	After you return and receive your report of findings, your recommended treatment program will be explained to you.
STEP EIGHT:	Treatment will begin and continue as scheduled until your condition has been fully corrected, or until maximum possible improvement has been obtained.

AQUAINTANCE INFORMATION

THE DATA ON THIS CONFIDENTIAL FORM IS ESSENTIAL IF WE ARE TO RENDER THE BEST PROFESSIONAL CARE.
WE APPRECIATE YOUR COOPERATION IN FILLING IT OUT SO THAT WE WILL HAVE ACCURATE RECORDS.
PLEASE PRINT. THANK YOU.

DATE _____

PERSONAL INFORMATION

PATIENT'S LAST NAME	FIRST NAME		HOME PHONE
HOME ADDRESS		CITY/TOWN	POSTAL CODE
DATE OF BIRTH DD: MM: YY:	OCCUPATION	EMPLOYER	BUSINESS PHONE
BUSINESS ADDRESS			
MARITAL STATUS	NAME OF SPOUSE	OCCUPATION	BUSINESS PHONE
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?		BY WHO WERE YOU REFERRED?	
EMERGENCY CONTACT #		EMAIL ADDRESS	

HEALTH CARE INSURANCE PLANS

ALBERTA HEALTHCARE #	OTHER HEALTH INSURANCE:

CHIROPRACTIC HEALTH INFORMATION

Please circle or check your answer to each question.

Have you had previous chiropractic care? Yes No Doctor: _____ Were X-rays taken? Yes No

What were you treated for: _____

What is your major complaint at present time: _____

What makes it feel better: _____

How long have you had this condition: _____

Have you had this or a similar condition in the past? Yes No When? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No When? _____

Is this condition interfering with your: Work __ Sleep __ Daily Routine __ Other _____

Other complaints (Please List) _____

_____

How long has it been since you felt really good? _____

Please list any surgical operations & year performed _____

Name of Medical Doctor _____

Are you currently taking Birth Control Pills __ Insulin __ Muscle Relaxants __ Nerve Pills __
Heart Medication __ Pep Pills __ Tranquilizers __ Pain Medication __ Vitamins __

Age of Mattress: ____ years Comfortable __ Uncomfortable __ How do you sleep? Back __ Side __ Stomach __ Combination __

Have you ever been in an auto accident? Yes No Please describe: _____

_____

Have you had any other personal injury or accident? Past Year __ Past 5 Years __ Over 5 Years __ None __

Please Describe _____

Interests & Hobbies _____

MEDICAL HEALTH INFORMATION

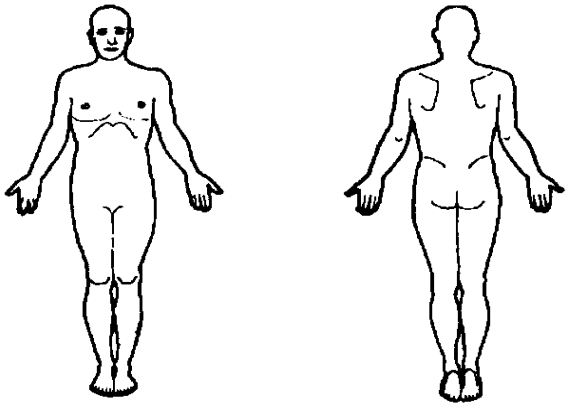
Have you ever been diagnosed or told you have any of the following? Please circle your response.

1.	High blood pressure	Yes	No
2.	Hardening of the arteries (arteriosclerosis)	Yes	No
3.	Diabetes	Yes	No
4.	Tuberculosis	Yes	No
5.	Cancer, Where:	Yes	No
6.	Heart or blood diseases	Yes	No
7.	Bone spurs on the neck bones (cervical sprain)	Yes	No
8.	Whiplash injury (flexion-extension injury, cervical sprain)	Yes	No
9.	Have you or any of your relatives ever suffered a stroke?	Yes	No
10.	Were you ever a smoker? From: To:	Yes	No
11.	Visual disturbances (blurring, loss, double)	Yes	No
12.	Hearing disturbances (loss, ringing, other noise)	Yes	No
13.	Slurred speech or other speech problems	Yes	No
14.	Difficulty swallowing	Yes	No
15.	Dizziness	Yes	No
16.	Loss of consciousness, even momentary blackouts	Yes	No
17.	Numbness, loss of sensation, strength or weakness in the face, fingers hands, arms, legs or any other parts of the body	Yes	No
18.	Sudden collapse without loss of consciousness	Yes	No

On the picture below, use the indicated marks to show areas where you have, **<u>at any time</u>** experienced:

PAIN: XXXX NUMBNESS: //// TINGLING: 0000

Then circle the areas you are currently experiencing.



For the dominant area of pain, how would you judge that pain on a scale of zero to ten?
(Zero is no pain, and 10 is the worst pain imaginable) Place an X on the corresponding value on these scales:

On the average:

0 **10**

At its worst:

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 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 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 consequence 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 you chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FROM 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.

_____

Name (Please Print)

_____ Date: _____ 20_____

Signature of patient (Or legal guardian)

_____ Date: _____ 20_____

Signature of Chiropractor