CONFIDENTIAL PATIENT CASE HISTORY

Name _____ **Health Card #** _____

Address _____**City** _____ **Province** _____ **Postal Code** _____

Home Number_____**Work Number**_____**Cell Number**_____

Age _____ **Birth date** _____(mm/dd/yy)_ Sex **M** □ **F** □ **Marital Status: M S W D**

Work Address _____ **Occupation** _____

Referred by _____

e-mail address _____

(used for appointment reminders and confirmations)

Is this a □ **Worker's Compensation Injury?** □ **Motor Vehicle Accident? If Yes Claim Number**_____

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case. Thank You.

Have you had previous chiropractic care? _____ By whom?_____

When? _____ For What Condition?_____

List Surgical Operations and Years_____

Drugs you now take or have taken in the past year: □ Pain Killers □ Muscle relaxants □ Birth Control Pills □ Aspirin
□ Corticosteroids □ blood thinners □ Other _____

Do you smoke: □ Yes □ No If Yes - how much? _____

Have you been in an auto accident? □ Yes □ No When? _____

Describe: _____

Have you ever had x-rays taken of your spine? □ Yes □ No When? _____

Do you participate in a regular exercise program? □ Yes □ No Describe: _____

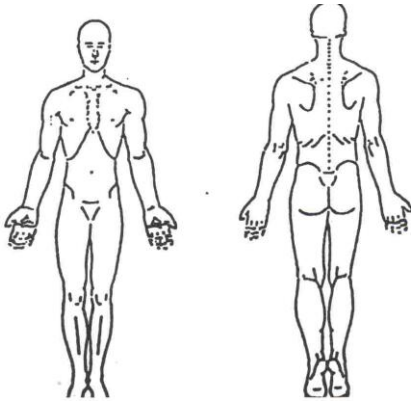
Are you currently pregnant? □ Yes □ No If Yes - how many weeks _____

Have you been diagnosed with any of the following?
□ Diabetes □ Arthritis □ Stroke □ High Cholesterol
□ High Blood Pressure □ Cancer □ Transcient Ischemic Attacks □ Other _____

Date of Last Physical Examination: _____ Name of Family Medical Doctor:_____

Approximate Height _____Weight _____

Please mark your areas of pain on the figures below:



Family Health History:
We are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you nay have about your:

Children (& Ages)_____
_____
_____
Spouse _____
Mother_____
Father _____
On a scale of 1 - 10, describe your stress level (1= None/ 10= Extreme):
Occupational _____ Personal _____
On a scale of Poor, Good, Excellent, describe your:
Diet _____Exercise _____Sleep _____General Health_____

NAME: _____ **DATE:**_____

As a full spectrum Chiropractic office, we focus on your potential to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. The following information addresses the health concerns that brought you to our office:

If you have no symptoms or complaints, and are here for wellness services, please check here □.
Others need to complete the following questions:

1. Reason for consulting the clinic: _____
_____
_____

2. How long have you had your primary complaint? _____
_____

3. How did it start?_____
_____
_____

4. Is it: □ improving □ staying the same □ getting worse □ comes and goes

5. Is it worse in the: □ morning □ afternoon □ evening □ night

6. What makes it worse? (e.g. sitting/stand/lifting) _____
_____
_____

7. What makes it better? (e.g. rest/medication/ice/heat)_____
_____
_____

8. If you are employed, please describe what activities you do on a daily basis(for example, lifting, typing, prolonged standing, sitting): _____
_____

9. Yes, it interferes with: □work □ sleep □hobbies □ leisure activities

10. Previous types of care: □Chiropractic □ Massage □Physical Therapy □Medical Doctor □ Specialist □Other _____

Health Conditions - please circle any symptoms you have experienced during the past 12 months

Respiration
chronic cough
chest pain
difficult breathing
asthma

Gastrointestinal
nausea
vomiting
diarrhea
indigestion
ulcers
heartburn
constipation

Cardiovascular
high blood pressure
hardening of arteries
swollen ankles

Neurological
visual disturbances
co-ordination difficulties
dizziness
slurred speech
headache
facial numbness
difficulty swallowing

Muscle and Joints
stiff neck **arthritis**
backache **spinal curvature**
neck pain **faulty posture**
swollen joints
foot trouble
pain in shoulders
loss of balance

ARGYLE NATURAL HEALTH CENTRE

"your natural choice for health care"
3643 Sherwood Drive, Regina SK S4R 4A7
Tel: (306) 352-4242 Fax (306) 352-1573

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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 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 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 of 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 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 to 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 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 your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM 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