

III. Health Information

Are you currently taking any medications? Yes No
If yes, please list them: _____

Are you currently taking any vitamins and supplements? Yes No

Have you ever had any serious illness/surgeries or been hospitalized? If so, please list details:

List all serious trauma, accidents, or injuries _____

Please list any X-rays with dates when they were taken

Please list any allergies

Do you wear: Arch supports or orthotics Heel lifts

Is there a family history of any of the following?

	Heart Disease	Arthritis	Cancer	Diabetes	Autoimmune conditions	Other (please list)
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Females only)

Are you pregnant? Yes No

Do you have any problems with your menstrual cycle?

Have you reached menopause? _____ Surgical or physiological? _____

Have you had a Mammogram? Yes No
If yes, when was it performed? _____
What were the results? _____

Are you currently, or have you in the past, been on hormone replacement therapy? Yes No

Are you currently taking oral contraceptives? Yes No

Have you has a bone mineral density test? Yes No

If yes, when was it performed and what were the results? _____

IV. Personal/ Social History

Do you participate in a regular exercise program? If yes, what type of activity and how many hours per week? _____

Do you eat a balanced diet? _____ Describe _____

Do you get enough sleep? _____ If no, is it due to pain? _____ How many hours? _____

Have there been any changes in your bowel or bladder habits? _____

Do you smoke? Yes No If yes, how many cigarettes per day? _____ For how long? _____

Have there been any significant stressors in your life lately? _____

How do you handle stress? _____ Has this changed recently? _____

V. Health History

Have you ever experienced or been diagnosed with any of the following? Please circle those which apply.

Alcoholism	Diarrhea or constipation	Heart Disease	Numbness or tingling	Sinus conditions
Anemia	Diabetes	Herniated Disc	Osteoporosis	Sleep disturbance
Anorexia or Bulimia	Difficulty hearing	Herpes	Overall weakness	Small Pox
Appendicitis	Difficulty walking	High Cholesterol	Pacemaker	Sore throat
Arm pain	Digestive disorders	Irregular heartbeat	Pain between shoulders	Spinal injury
Arthritis	Dizziness or Fainting	Jaw pain	Parkinson's Disease	Stroke
Asthma/allergies	Eczema	Joint pain/stiffness	Pinched Nerve	Suicide Attempt
Back pain	Emphysema	Kidney condition	Pleurisy	Swollen ankles
Black/bloody stool	Epilepsy	Liver Disease	Pneumonia	Thyroid Problems
Bladder problems	Excessive thirst	Low back pain	Polio	Tonsillitis
Bleeding Disorders	Fatigue	Lung disease	Poor or excessive appetite	Tuberculosis
Breast Lump	Forgetfulness	Measles	Productive cough	Tumors, Growths
Bronchitis	Fractures	Mental disorders	Prostate Problems	Typhoid Fever
Cancer	Frequent nausea	Miscarriage	Prosthesis	Ulcers
Cataracts	Gain or loss of weight	Mononucleosis	Psoriasis	Vaginal Infections
Chemical Dependency	Glaucoma	Multiple Sclerosis	Psychiatric Care	Venereal Disease
Chicken Pox	Gonorrhea	Mumps	Rheumatic Fever	Vision problems
Chronic infection	Gout	Neck pain	Rheumatoid Arthritis	Vomiting
Convulsions	Headaches	Night sweats	Shortness of breath	Whooping Cough
Depression				

Do you have a history of high blood pressure? Yes No

Is there anything else the doctor should know about your health?



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment **FORM - L**

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments 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 have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
- b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;
- c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, 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 associated 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.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____
(please print)

Name: _____
(please print)