PRECISION
SPINAL & WELLNESS CENTRE

Phone: 609-8385 Fax:609-8328

CONFIDENTIAL CASE HISTORY

Date: ___________________

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

--PERSONAL INFORMATION--

Name: ❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Dr. ____

Gender : ❑ M ❑ F

Marital Status: ❑ M ❑ S ❑ W ❑ D   Alberta Health Card Number: ________________________

Address: ____ City: _________________________

Postal Code: _________________ Home Phone: ______________ Business Phone: _________

Emergency Contact Name______________________ Phone_____________________________

Date of Birth: dd_____mm_____yr_____ e-mail address: _______________________________

Employer: _________________________ Occupation: _________________________________

Hobbies: (What occupies your spare time?) ____

Spouse's or Partner's Name: ________________________Children(number)______________

How did you hear about our office? ____

---HEALTH INFORMATION---

Have you ever been to a chiropractor before? ❑ No Yes Doctor's Name: __________________

When was your last visit? ________________ What was the problem? _____________________

What was your result? ____

Have you had previous healthcare for this problem? ❑ Yes ❑ No

Where? ______________________________ When? __________________________________

Were x-rays taken? ____

IS THERE ANY CHANCE YOU COULD BE PREGNANT? ❑ Yes ❑ No

*******If You think you **are pregnant** please let the doctor know******

PLEASE INDICATE THE FIRST DAY OF YOUR LAST MENSTRUAL CYCLE________________

-------------------------------------REASON FOR CONSULTING OUR OFFICE------------------------------

❑ **I have a specific problem and require help only with this problem.**

❑ **After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.**

❑ **After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.**

❑ **I have no symptoms and feel well. I am interested in strategies to help me to continue to feel well, or even better.**

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1) What is your primary health concern?____

How long have you had this condition?____

How often do you notice it? Always --- Daily --- Weekly --- Monthly --- Yearly --- other_______

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

One a scale of 1-10 describe your level of discomfort (0 none 10 severe) ___________________

Have you had this or similar conditions in the past? ❑ No ❑ Yes, and when? ________________

If you are experiencing discomfort, how would you describe it? (dull, sharp, heavy..)___________

Does the sensation travel anywhere?____

What activities aggravate your condition?____

What makes it better? ____

What do you think is the cause of your problem?____

What is your health expectation?____

Is this condition interfering with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other ______________

On a scale of 1-10 describe your stress level:

(1=none, 10= extreme)   Occupational:_____   Personal:_____

How long has it been since you really felt well? ____

2) What is your Secondary health concern?____

How long have you had this condition?____

How often do you notice it? Always --- Daily --- Weekly --- Monthly --- Yearly --- other_______

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

One a scale of 1-10 describe your level of discomfort (0 none 10 severe) ___________________

Have you had this or similar conditions in the past? ❑ No ❑ Yes, and when? ________________

If you are experiencing discomfort, how would you describe it? (dull, sharp, heavy..)___________

Does the sensation travel anywhere?____

What activities aggravate your condition?____

What makes it better? ____

What do you think is the cause of your problem?____

3) Other health concerns?____

How long have you had this condition?____

How often do you notice it? Always --- Daily --- Weekly --- Monthly --- Yearly --- other_______

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

One a scale of 1-10 describe your level of discomfort (0 none 10 severe) ___________________

Have you had this or similar conditions in the past? ❑ No ❑ Yes, and when? ________________

If you are experiencing discomfort, how would you describe it? (dull, sharp, heavy..)___________

Does the sensation travel anywhere?____

What activities aggravate your condition?____

What makes it better? ____

What do you think is the cause of your problem?____

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Has there been any medical diagnosis of your complaint? ❏No ❏ Yes , if yes list the Dr.'s name and diagnosis:

____

Are there any other Health conditions that we should know about?_________________________

List surgeries, broken bone, and major illnesses (including childhood):_________________________
____
____

Any family health conditions or problems: ☐ Yes ☐☐ No Please list: ________________________

Age of Mattress: _____ Comfortable: ❏ Yes ❏ No Do you sleep on your stomach? ❏ Yes ❏ No

Do you wear ❏ Heel Lifts ❏ Sole Lifts ❏ Inner soles ❏ Arch supports ❏ Orthotics

Is your problem the result of a work injury or an auto accident?

Have you been in an auto accident: ❏ Never ❏ Past year ❏ Past 5 years ❏ Over 5 years

Is there or might there be a lawyer involved? ❏ Yes ❏ No

Description of accident:____

____

____

Have you had any significant injury in your lifetime: ❏ None ❏ Past year ❏ Past 5 years ❏ other_____

Description of accident: ____

____

Have you ever been knocked unconscious: ☐ Yes☐☐ No☐☐ Don't know

If so, for how long & describe what happened:____

Date of most recent physical examination: ____

--HABITS OF LIFESTYLE---

Do you smoke:☐ Yes☐☐ No ____Pack(s)/day Alcohol Consumption: ☐ Yes☐☐ No #drinks weekly:____
Exercise/week (in hours)_______ Average Intensity Level (circle): Low—Moderate-- High Activity types: _________________ Stretching:_____hr/wk Resistance training ______hr/wk
Do you drink beverages with caffeine: ☐ Yes☐☐ No If yes, how many glasses daily: _____
How many glasses of water do you drink per day: 0 –1--2– 3--4—5—6—7—8—9—10—11---12+
Rate your sleep, hours per night: 4 5 6 7 8 9 10 11 12+
Do you wake rested: ☐ Yes☐ ☐ No
Do you feel overly fatigued during the course of a day: ☐ Yes☐☐ No
Rate your diet: 1)Poor 2)Fair 3)Medium 4)Good 5)Excellent
Do you eat regularly: ☐☐Breakfast ☐☐Lunch ☐☐Dinner
List any Prescription Drugs, Over the counter Drugs, Vitamins and Natural Supplements you are currently taking and WHY?:

What are you currently taking?	What is it for?

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Please mark the areas on the figures of pain and/or discomfort:

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull	**S = Stabbing/Sharp**
B = Burning	**T = Tingling (Pins & Needles)**
N = Numb	**C = Cramping**

R **L** **L** **R**

PATIENT HISTORY FORM

Please check the appropriate box for any of the following symptoms that you may have.

C= Constant F= Frequent *(weekly)* **0= Occasional** *(monthly/yearly)*

C	**F**	**O**	**NEUROLOGICAL**	**C**	**F**	**O**	**Con't**	**C**	**F**	**O**	**PAIN,NUMBNESS, TENSION**
☐	☐	☐	Lower resistance	☐	☐	☐	Failing vision	☐	☐	☐	Shoulders
☐	☐	☐	Allergy	☐	☐	☐	Far sighted	☐	☐	☐	Arms
☐	☐	☐	Chills	☐	☐	☐	Hay Fever	☐	☐	☐	Hands
☐	☐	☐	Convulsions	☐	☐	☐	Hoarseness	☐	☐	☐	Hips
☐	☐	☐	Dizziness	☐	☐	☐	Nasal obstruction	☐	☐	☐	Legs
☐	☐	☐	Fainting	☐	☐	☐	Near sighted	☐	☐	☐	Knees
☐	☐	☐	Fevers	☐	☐	☐	Nosebleeds	☐	☐	☐	Ankles
☐	☐	☐	Headaches	**C**	**F**	**O**	**CARDIO-VASCULAR**	☐	☐	☐	Feet
☐	☐	☐	Migraines	☐	☐	☐	Rapid heart beats	☐	☐	☐	Painful tail bone
☐	☐	☐	Loss of sleep	☐	☐	☐	Slow heart beats	☐	☐	☐	Sciatica
☐	☐	☐	Nervousness	☐	☐	☐	Swelling of ankle	☐	☐	☐	Swollen joints
☐	☐	☐	Depression	☐	☐	☐	Hardening of arteries	**C**	**F**	**O**	**WOMEN ONLY**
☐	☐	☐	Neuralgia/nerve pain	☐	☐	☐	High blood pressure	☐	☐	☐	Cramps
☐	☐	☐	Numbness	☐	☐	☐	Low blood pressure	☐	☐	☐	Heavy flow
☐	☐	☐	Sweats	☐	☐	☐	Pain over heart	☐	☐	☐	Light flow
☐	☐	☐	Loss of weight	☐	☐	☐	Poor circulation	☐	☐	☐	Irregular cycle
☐	☐	☐	Tremors	**C**	**F**	**O**	**GASTRO INTESTINAL**	☐	☐	☐	Painful cycle
C	**F**	**O**	**MUSCLE & JOINT**	☐	☐	☐	Excessive hunger	☐	☐	☐	Discharge
☐	☐	☐	Arthritis	☐	☐	☐	Burping or gas	☐	☐	☐	Sore breasts
☐	☐	☐	Bursitis	☐	☐	☐	Liver troubles				
☐	☐	☐	Foot trouble	☐	☐	☐	Colitis				
☐	☐	☐	Hernia	☐	☐	☐	Colon troubles				
☐	☐	☐	Low back pain	☐	☐	☐	Constipation				
☐	☐	☐	Neck pain	☐	☐	☐	Diarrhea				
☐	☐	☐	Neck stiffness	☐	☐	☐	Difficult digestion				
☐	☐	☐	Pain between shoulder	☐	☐	☐	Distension of abdomen				
☐	☐	☐	Spinal curvature	☐	☐	☐	Stomach pain				
☐	☐	☐	Jaw clicking	☐	☐	☐	Gall bladder trouble				
☐	☐	☐	Jaw pain	☐	☐	☐	Hemorrhoids				
C	**F**	**O**	RESPIRATORY	☐	☐	☐	Intestinal worms				
☐	☐	☐	Chest pain	☐	☐	☐	Jaundice				
☐	☐	☐	Chronic cough	☐	☐	☐	Poor appetite				
☐	☐	☐	Difficulty breathing	☐	☐	☐	Nausea				
☐	☐	☐	Spitting blood	☐	☐	☐	Vomiting				
☐	☐	☐	Throat phlegm	☐	☐	☐	Vomit blood				
☐	☐	☐	Wheezing	**C**	**F**	**O**	**SKIN**				
C	**F**	**O**	**EYES,EARS,NOSE,THROAT**	☐	☐	☐	Boils				
☐	☐	☐	Colds	☐	☐	☐	Bruise easily				
☐	☐	☐	Crossed eye	☐	☐	☐	Dryness				
☐	☐	☐	Deafness	☐	☐	☐	Hives or allergy				
☐	☐	☐	Dental decay	☐	☐	☐	Itching				
☐	☐	☐	Asthma	☐	☐	☐	Skin rash				
☐	☐	☐	Ear aches/infections	☐	☐	☐	Varicose veins				
☐	☐	☐	Ringing in ears	**C**	**F**	**O**	**GENTIO-URINARY**				
☐	☐	☐	Sinus infections	☐	☐	☐	Bed wetting				
☐	☐	☐	Enlarged glands	☐	☐	☐	Blood in urine				
☐	☐	☐	Enlarged thyroid	☐	☐	☐	Frequent urination				
☐	☐	☐	Sore throat	☐	☐	☐	Sexual dysfunction				
☐	☐	☐	Tonsillitis	☐	☐	☐	Urinary troubles				
☐	☐	☐	Eye pain								

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MEDICAL DOCTOR:

Name: ____________________________ Date of Last Appointment: ____________

MEDICAL SPECIALIST:

Name: ____________________________Specialty: _________________________

Date of Last Appointment: __________________________

DENTIST:

Name: ____________________________Date of Last Appointment: ___________

DENTAL SPECIALIST:

Name: _____________________________Specialty: _________________________
Date of Last Appointment:___________________________

List Past Dental Procedures:

____

____

____

NATUROPATH/NUTRITIONIST:

Name: ___________________________ Date of Last Appointment: ____________

MASSAGE THERAPIST

Name: ___________________________ Date of Last Appointment: ____________

PHYSICAL THERAPIST:

Name: ___________________________ Date of Last Appointment: ____________

FITNESS FACILITY:

Name: ___________________________ Trainer_____________________________

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PRIVACY & DISCLOSURE OF USING FIRST AND LAST NAME

As one of our patients, we hold both your health and your privacy in the highest esteem. We would like your permission to confer with other members of your health care team as well as with other practitioners who we feel may be of assistance.

If there is anyone you are currently aware of that you would like us not to contact, please list his or her names in the area provided below. We will use our professional discretion to protect your privacy, while ensuring that you have the best opportunities for wellness that we can provide.

I do not want the following individual to be contacted:

____

This office is required, by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of legal duties and privacy practices with respect to the use of your name.

By way of signing this form, I release this office from all liability and authorize the use of my first and last for the purpose of announcing me into a room, or around the office in the presence of others. We also ask your permission to thank those who referred you to our practice.

NAME(print):____

DATE____

Signature:____
(patient/guardian)

PRECISION
SPINAL & WELLNESS CENTRE

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does 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 the 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 burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.
I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.
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:__________________________ Name:______________________________
(please print) **(please print)**