Welcome to the Alpine Chiropractic Health Centre

Alberta Health Care #:_____ Date:_____

Last name:_____ First name:_____ Middle name or initial:_____

Date of birth (day/month/year);_____/_____/_____

Mailing Address:_____ Home phone: (___) _____

_____ Work phone: (___) _____

City:_____ Prov/State:_____ Postal code:_____ Mobile: (___) _____

Email: _____

Emergency Contact name (relation):_____ Phone: (___) _____

How did you here about our clinic? ☐Phone book ☐Ad ☐ Sign ☐ Person (name):_____

Would you like a reminder for your appts? Email/SMS If SMS, name of cell carrier:_____

Employer:_____

Occupation:_____

Extended Health Care Insurance:_____ ID#:_____

Is this a work related injury? Yes / No If yes, date of injury:_____ WCB Claim #:_____

Is this a motor vehicle or personal injury claim? Yes / No If yes, date of injury:_____

Prior Chiropractic Care? Yes / No Name:_____ Location:_____

X-Rays taken? Yes / No Treatment results: Excellent Good Fair Poor

Medical Doctor: Name:_____ Phone: (___) _____

Date of last appointment:_____ Date of last physical (if known):_____

Review of systems: Please check any symptoms you have or have had in the last two years:

GENERAL
- ☐ Bruise easily
- ☐ Depression
- ☐ Dental Problems / TMJ
- ☐ Difficulty Sleeping
- ☐ Fainting
- ☐ Fever
- ☐ Pain that wakes you up at night
- ☐ Unexplained weight loss or gain

MUSCULOSKELETAL
- ☐ Headache
- ☐ Neck pain
- ☐ Mid Back pain
- ☐ Low Back Pain
- ☐ Shoulder / Arm / Wrist
- ☐ Hip / Knee / Ankle

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation/Diarrhoea
- ☐ Gas/ Heartburn
- ☐ Excessive hunger/thirst
- ☐ Black stool
- ☐ Rectal bleeding
- ☐ Appendicitis
- ☐ Vomiting/Nausea

CARDIOVASCULAR
- ☐ High/Low blood pressure
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE THROAT
- ☐ Vision changes/problems
- ☐ Difficulty swallowing
- ☐ Ear Ache / Ringing
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Hay fever / Allergies
- ☐ Sinus problems

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

NERVOUS SYSTEM
- ☐ Numbness / Tingling
- ☐ Dizziness / Vertigo
- ☐ Forgetfulness
- ☐ Convulsions / Paralysis

MEN Only
- ☐ Breast lump
- ☐ Erectile difficulties
- ☐ Lump in testicles
- ☐ Prostate problems

WOMEN Only
- ☐ Abn. bleeding
- ☐ Breast lump
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ Date of last period_____
- ☐ Date of last Pap Smear_____
- ☐ Have you had a mammogram?____
- ☐ Are you pregnant? Yes / No

Any other medical conditions:_____

Do you smoke? Yes / No ____ per day Do you drink alcohol? No / Socially / On a regular basis ___ per week

Have you ever had any surgery?_____

Please list any current prescriptions:_____

Have you ever fractured any bones?_____

Please check if any of your immediate family members have a history of the following:

☐ Cancer ☐ CV Disease ☐ Diabetes ☐ Other major illnesses_____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
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 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