

ABOUT THIS OFFICE

The wellness clinic has a philosophy to health that involves a multidiscipline approach to health and health care. It involves the relief of pain and symptoms, full rehabilitation, and education and exercise, nutrition and stress management. These factors together in general well being and lead to a better quality and enjoyment of life. It is your choice to receive these different I Please underline any conditions which are presently causing you a problem. Please check (✓) those conditions which were a problem to you in the past.

<p>GENERAL SYMPTOMS Headache Fever Chills Sweats Fainting Dizziness Convulsions Loss of sleep Fatigue Nervousness Loss of weight Numbness or pain in arms, hands, legs Allergy Wheezing Neuralgia</p> <p>E.E.N.T Failing vision Near sightedness Far sightedness Crossed eyes Eye pain Deafness Earache Ear Discharge Nose bleeds Nasal destruction Hoarseness Sore throat Hay fever</p>	<p>E.E.N.T. (cont'd) Asthma Dental decay Gum trouble Frequent colds Enlarged thyroid Tonsillitis Sinus infection Nasal discharge Enlarged glands</p> <p>SKIN Sink eruptions Itching Bruises easily Dryness Boils Varicose veins Sensitive skin Hives or allergy</p> <p>RESPIRATORY Chronic or cough Spitting or phlegm Spitting up blood Chest pain Difficult breathing</p>	<p>Cardio Vascular Low blood pressure Pain over heart Previous heart stroke Hardening of arteries Swelling of ankles Poor circulation Paralytic stroke</p> <p>MUSCLE & JOINT Stiff neck Back ache Neck pain Swollen joints Painful tail bone Foot trouble Pain in shoulders Hernia Spinal curvature Faulty posture Arthritis</p> <p>GENTOURINARY Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Bed wetting Inability to control urine Prostate trouble</p>	<p>GASTROINTESTINAL Poor Appetite Difficult digestion Excessive hunger Belching or gas Nausea Vomiting Vomiting of blood Colon trouble Constipation Intestinal worms Liver trouble Gall bladder trouble Jaundice Colitis Pain over stomach Hemorrhoids (Piles)</p> <p>FOR WOMEN ONLY Painful menstruation Irregular cycle Cramps or backache Previous miscarriage Vaginal discharge Congested symptoms Excessive flow Lumps in breast Menopausal symptoms Excessive flow Hot flashes Number of pregnancies Number of abortions Number of miscarriages</p>	<p>CHILDHOOD CONDITIONS Measles Scarlet fever Ear infections Mumps Diphtheria Tubes in ears Chickenpox Rheumatoid fever Whooping cough Typhoid fever Other</p>
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HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? IF SO, PLEASE INDICATE.

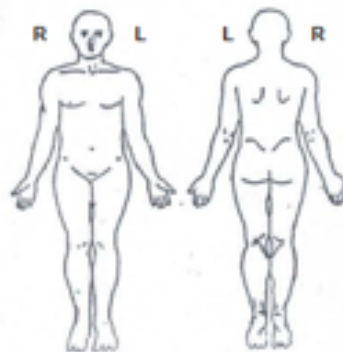
Aneurysm	High blood	Hepatitis	Polio	Sleeping
Cancer	pressure	Fatigue	HIV	difficulty
Respiratory	Heart	Arthritis	Osteoporosis	Psoriasis
conditions	condition	Diabetes	Stroke	Pneumonia

VISUAL PAIN RATING SCALE

INSTRUCTIONS: Make a mark (/) along the line which you think represents your current level of pain in your major area of injury, somewhere between "NO PAIN AT ALL" and "PAIN AS BAD AS IT COULD BE"

NO PAIN AT ALL _____ **PAIN AS BAD AS IT COULD BE**

PAIN DIAGRAM



On the following diagrams, indicate all areas of;

Stiffness ////

Burning xxxx

Aching *****

Numbness ● ●

What level of care are you interested in pursuing? (please mark below)

pain relief

pain relief with rehabilitation through exercise

prevention which involves looking at nutrition, stress management, exercise, postural analysis and good spinal health.

Expectations _____

PATIENT QUESTIONNAIRE (Please Circle)

Any recent diagnostic imaging CT scan, MRI, Ultrasound **YES NO** Date _____

Any recent spinal x rays **YES NO** Date _____

Have you ever been to a chiropractor before **YES NO** Date _____

Results: excellent good fair poor Dr.'s name: _____

Do you take any vitamin or mineral supplementation. If yes please list them

Sleeping posture Side Back Stomach How many pillows do you sleep with? _____

Have you ever been knocked unconscious? **YES NO**

Are you presently under treatment for this problem? **YES NO**

Are you presently taking any medications? **YES NO**

If yes, please list medications _____

Are you presently pregnant? **YES NO** If **YES**, due date is

Are you a smoker? **YES NO** If **YES**, amount per day _____

Do you exercise? (if yes please outline activities below) **YES NO**

Do you consume alcohol? **YES NO**

Indicate your sleep, hours per night

Do you wake rested? **YES NO**

Accidents or falls / Fractures or Dislocations (Please describe fully)

Please start with the most recent _____

Have you had any surgeries? (if yes please outline)

In signing this form you agree that this information is correct

Signature _____ Date _____

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)

_____ Signature of patient (or legal guardian)

_____ Signature of Chiropractor

Date: _____ 20____ Date: _____ 20____