CLOVERDALE CHIROPRACTIC

RESTORE | EMPOWER | THRIVE

New Patient Admittance Form

Welcome to Cloverdale Chiropractic. The information you provide helps us to understand better the nature of your condition. We kindly ask that you complete this admittance form to the best of your knowledge. All information gathered will remain confidential and only be shared with those you have granted consent.

Date: _____

Name: _____

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Home phone: _____ Cell phone: _____

Email address: (for appointment reminders) _____

Date of birth: (DD/MMM/YYYY) _____

BC MSP Healthcare #: _____

Occupation: _____

Employer: _____

Referred by: _____

Emergency contact (name and phone #): _____

_____

Health History

CARDIOVASCULAR

- ❑ Angina
- ❑ Ankle swelling
- ❑ Arrhythmias
- ❑ Arteriosclerosis
- ❑ Blood clots
- ❑ Chest pain
- ❑ Cold/Blue hands, feet
- ❑ Heart attack
- ❑ High blood pressure
- ❑ Shortness of breath
- ❑ Stroke

Musculo-Skeletal

- ❑ Arthritis
- ❑ Back pain
- ❑ Disc problems
- ❑ Fractures
- ❑ Hip/knee/foot pain
- ❑ Gout
- ❑ Muscle cramps
- ❑ Muscle injury/strains/tears
- ❑ Neck pain
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Shoulder/arm/hand pain

Neurological

- ❑ Alzheimer's disease
- ❑ Blindness
- ❑ Blurred/double vision
- ❑ Epilepsy
- ❑ Fainting
- ❑ Headaches
- ❑ Memory problems
- ❑ Numbness/tingling
- ❑ Sciatica
- ❑ Seizures
- ❑ Tinnitus
- ❑ Tremors

Gastro-Intestinal

- ❑ Acid reflux
- ❑ Bloody/black stool
- ❑ Crohn's disease
- ❑ Irritable bowel syndrome
- ❑ Ulcers
- ❑ Vomiting

Other Conditions

- ❑ Cancer
- ❑ Depression
- ❑ Hepatitis
- ❑ Multiple sclerosis
- ❑ Night sweats

Family History

- ❑ Arthritis
- ❑ Autoimmune
- ❑ Cancer
- ❑ Heart disease
- ❑ Stroke

Past fractures: _____

_____

Past surgeries: _____

_____

Past hospitalizations: _____

_____

Present Condition

Chief Complaint: _____

When did this condition begin: _____

How did this condition begin: (Please inform the receptionist if this complaint is an ICBC or WorkSafe BC claim)

_____

_____

_____

What makes this condition feel worse: _____

What makes this condition feel better: _____

How has this condition changed: ❒ Getting better ❒ Getting worse ❒ Staying the same

Please explain: _____

_____

Have you had previous treatment: ❒ Yes ❒ No

If yes, what type of treatment: _____

What was the result of treatment: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Please explain: _____

_____

Is there a particular time of day when this condition is worse:

❒ Morning ❒ Afternoon ❒ Evening ❒ Night

❒ After long periods of activity ❒ After long periods of rest

Have you had this condition before: ❒ Yes ❒ No

Please explain: _____

_____

_____

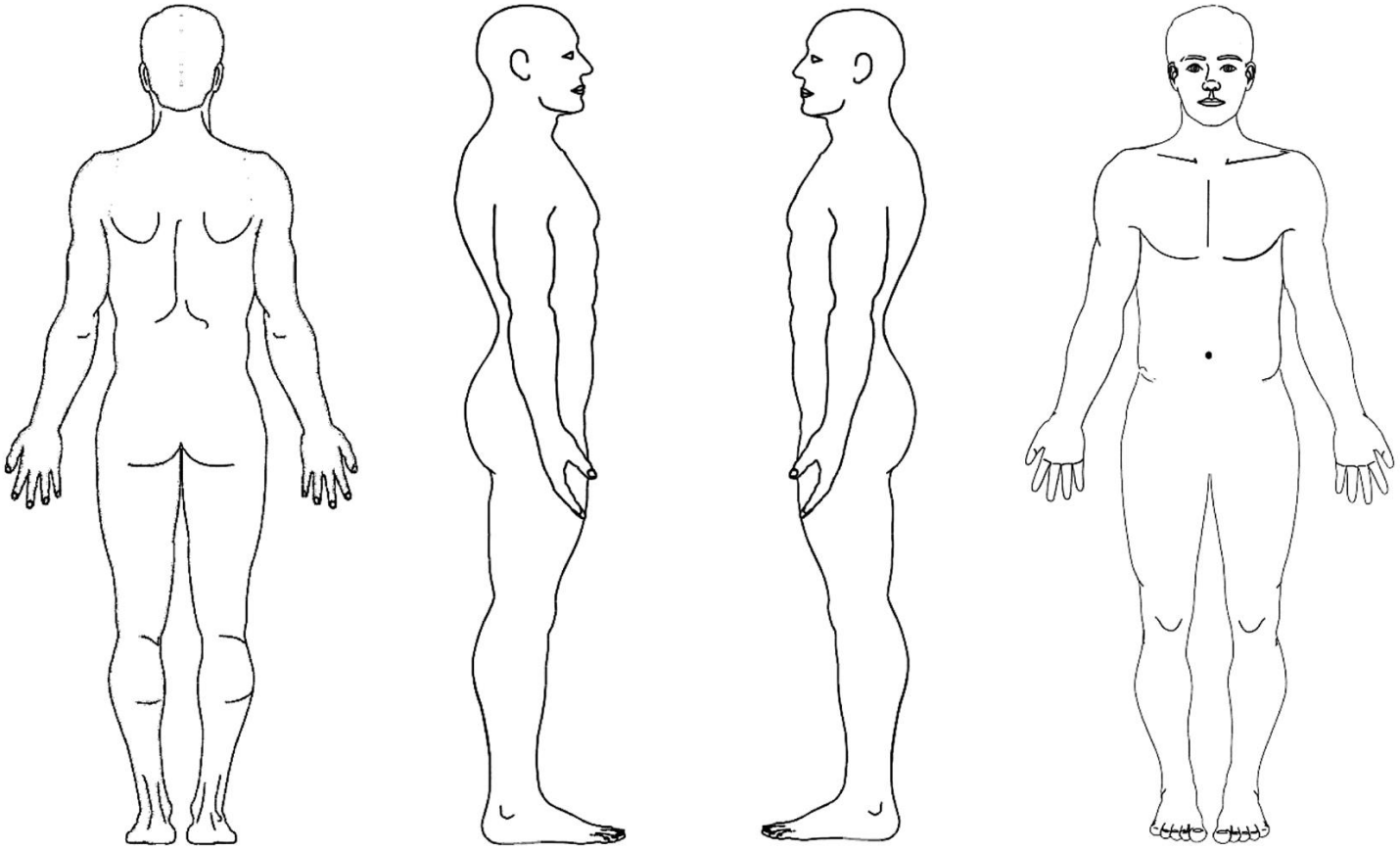
Present Condition

Place An (X) To Indicate Your Present Level Of Discomfort:

No Pain ——————————— Most Severe Pain Ever

In the diagrams below, please use the symbols provided to mark the areas on your body that best represent the symptoms that you are feeling and their locations.

Symbols:	Burning	XXXXX	Pins and Needles	/////	Numbness	WWWW
	Dull and Aching	+++++	Stabbing and Sharp	####	Stiff and Tight	::::



Before the examination and treatment begins, do you have any questions or concerns that you wish to discuss:

Informed Consent

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 associated 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.

Authorization For Treatment

Patient's Name	Witness Name
Patient's Signature	Witness Signature
Patient must be of legal age (18 years) to sign the consent	
Date	Date

Parent of Guardian

Name of parent or legal guardian	Signature of parent or legal guardian
Date	