CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name

____

FIRST NAME (PREFERRED) LAST NAME

What are your immediate goals/reasons for starting Chiropractic Health Care?

- ☐ **Back pain/ symptom relief**
- ☐ **Improve Flexibility & Movement**
- ☐ **Improve Health and Fitness**
- ☐ **Reduce Stress**
- ☐ **Lose Weight**
- ☐ **Generate better healing capacity**

- ☐ **Other (Applied Kinesiology Protocols)**
- ☐ **Dietary & Gut Health**
- ☐ **Emotional & Trauma Support**
- ☐ **Mindset & Wellness Blocks**
- ☐ **Behavioural & Growth Challenges**

HOW CAN WE HELP YOU?

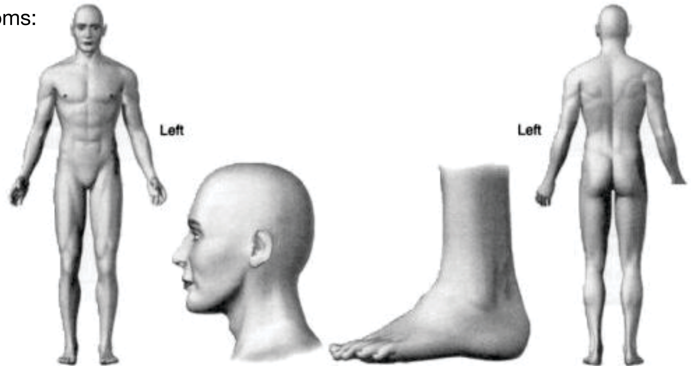
What brings you in today? ____

____

How bad is it? How intense are your symptoms? (circle) ⓪ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

NO SYMPTOMS — INTENSE SYMPTOMS

Please **mark** areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

- ❑ Numbness
- ❑ Sharp
- ❑ Tingling
- ❑ Shooting
- ❑ Stiffness
- ❑ Burning
- ❑ Dull
- ❑ Throbbing
- ❑ Aching
- ❑ Stabbing
- ❑ Cramping
- ❑ Swelling
- ❑ Nagging
- ❑ Other ____________________

1. (Complaint 1)

When did it start?____________________ How often does it occur? ☐ Constantly ☐ Daily ☐ On/Off

Is the problem getting? ☐ Worse ☐ Better ☐ Stays the same What makes it worse? ____________________

What makes it better? ____________________

2. (Complaint 2)

When did it start?____________________ How often does it occur? ☐ Constantly ☐ Daily ☐ On/Off

Is the problem getting? ☐ Worse ☐ Better ☐ Stays the same What makes it worse? ____________________

What makes it better? ____________________

What do you think caused these problem(s)? ____________________

Injuries, Falls, Slips and Accidents

1. When (Year)__________ What happened____________________

   Injuries ____________________ Treatment____________________

2. When (Year)__________ What happened____________________

   Injuries ____________________ Treatment____________________

Any broken bones/ reconstructions?____________________

Motor vehicle accidents (Did you know that the minimum speed to cause Subluxation is only 13 km/hr!)

1. When (Year)__________ Speed (kms)__________ Impact ☐ Front ☐ Side ☐ Back ☐ Stationary

   Injuries ____________________ Treatment____________________

2. When (Year)__________ Speed(kms)__________ Impact ☐ Front ☐ Side ☐ Back ☐ Stationary

   Injuries ____________________ Treatment____________________

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

☐ Neck pain / Stiff neck
☐ Headaches / Migraines
☐ Nervousness / Depression
☐ Asthma
☐ Digestive problems / IBS
☐ Low back pain
☐ Constipation / Diarrhoea
☐ Hip pain
☐ Reflux
☐ Bowel / Bladder problems
☐ Difficulty sleeping
☐ Fatigue
☐ Chest pain
☐ Recurrent colds / Flu
☐ Leg pain / Cramps
☐ Infertility
☐ Menstrual problems
☐ Dizziness / Ringing in the ears
☐ Allergies / Sinus
☐ Pain between shoulders
☐ Numbness / Tingling in legs/feet
☐ Numbness / Tingling in arms/hand
☐ Breathing issues
☐ Snoring
☐ Jaw pain
☐ Grinding / Clenching

Have you ever been diagnosed with any of the following? If YES please indicate WHEN.

☐ Cancer ___________ ☐ Heart Disease ___________ ☐ Diabetes ___________ ☐ Stroke ___________ ☐ Other ___________

List Treatments & Surgeries. What year? ____

____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity ___________	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other	❑	❑	❑	❑

How committed are you to correcting this issue? ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

NOT COMMITTED — VERY COMMITTED

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

____
____
____

MEDICATIONS (list)

____
____
____

SUPPLEMENTS (list)

____
____
____

Previous Treatments

Who else is involved in managing your complaint? (GP, Specialist, Physio, Osteo, Naturopath, Massage Therapist, Trainer?)

Doctor(s) or Practitioner(s) name: ____

Diagnosis & treatment proposed? ____

Have you been to a Chiropractor before? ☐ Yes ☐ No Dr's name & Date of last visit ___________________

Have you had Spinal X-rays? ☐ Yes ☐ No If YES what year? ___________ CT / MRI / Ultrasound / Other ? (please circle)

Do you use any of the following? ☐ Orthotics ☐ Shoe Insert ☐ Dental Appliance ☐ Glasses

Work or Study Habits

Hours worked/study per week ___________ At work, do you mainly? ☐ Sit ☐ Stand ☐ Lift ☐ Bend ☐ Twist

Do you consider your job stressful? ☐ Y N ☐ Does your health concern/symptoms impact your work? ☐ Y ☐ N

How would you rate your eating habits? ☐ Excellent ☐ Good ☐ Moderate ☐ Poor

How stressful is your lifestyle? Not stressful ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Stressful

How often you exercise? ☐ Daily ☐ 2–3 times per week ☐ Weekly ☐ Never

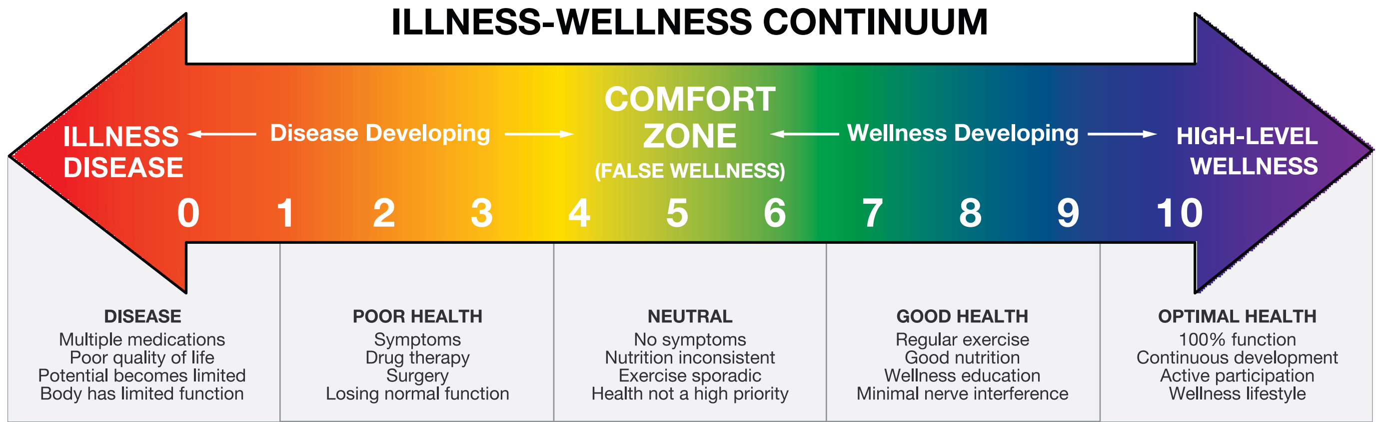
How much water do you drink a day? ___________________

Do you drink coffee? ☐ Yes ☐ No If YES how many cups per day? ___________

Do you drink Alcohol? ☐ Yes ☐ No If YES how much? ___________

Do you Smoke? ☐ Yes ☐ No If YES how many per day? ___________

PATIENT WELLNESS ASSESSMENT



DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? ______________________________

B. In what direction is your health currently headed? ______________________________

Informed Consent to Chiropractic Care & Massage Therapy

Chiropractic Adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medical and many other alternatives. *(A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993).*

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approximately 1 in 2.15 million). Other very slight risks include (but are not limited to) strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000) *[Dvorak study in Principles Practice of Chiropractic, Haldeman. 2ndEd.]*

If you have any questions related to the treatment that you are about to receive, please speak to your Chiropractor.

Clinical experience consistently demonstrates unexpected improvement in people's life. One study indicated 23% of people experience improvement in some other aspect of their health *(Leboeuf-Yde C, Axen I, Ahlefeldt G, Lidefelt P, Rosembaum A, Thurnherr T. The types of improved nonmusculoskeletal side effects of chiropractic treatment: a prospective study. Leboeuf-Yde C. J Manipulative Physio Ther. 1997 Oct; 20(8):511-5).*

Of Individuals who experience such improvements:

- 26% experienced improvements in their respiratory system
- 25% in their digestive system
- 14% circulatory system/heart
- 14% eyes/vision

(The references for the information quoted above are available upon request)

I have read the above and acknowledge I am aware of and understand the potential risks. I do not expect the chiropractor to be able to anticipate or explain all the risks and complications. I wish to rely on the chiropractor to exercise his/her judgement during the course of the procedures which he/she feels, at the time, based upon the facts known, is in my best interests.

I have to the best of my knowledge provided the chiropractor with a complete and accurate health history. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation.

I hereby request and consent to chiropractic adjustments, ancillary procedures and massage therapy wherever the chiropractor determines necessary. By signing below I agree to Chiropractic care. I understand that I can withdraw my consent at any time.

SIGNATURE______________________________ **PRINT NAME**______________________________

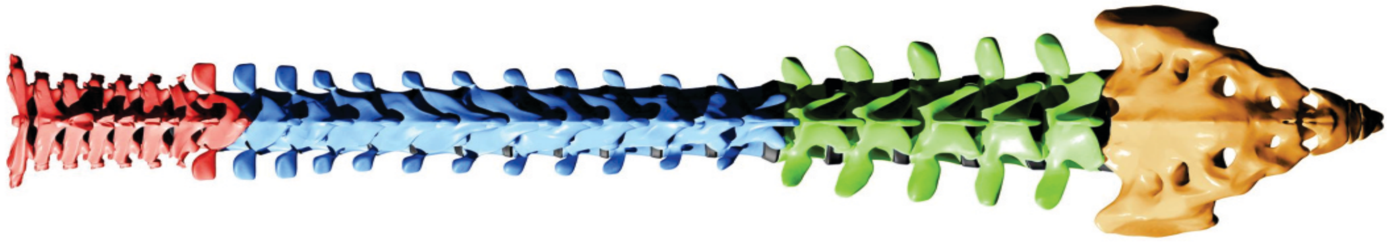
(Parent/Guardian if under 18 years) DATE____________________

CHIROPRACTOR'S SIGNATURE______________________________ DATE____________________

Doctors Use Only - Spinal Allostatic Loading

Key: **O** 1 = Restriction Mild — **X** 1 = Pain Mild

O 2 = Restriction Marked — **X** 2 = Pain Marked



ROM, Objective Findings

Cervical	pulling	pain	normal	Lumbar	pulling	pain	normal
Flexion			50	Flexion			60
Extension			60	Extension			25
Left Lat. Flex			45	Left Lat. Flex			25
Right Lat. Flex			45	Right Lat. flex			25
Left Rotation			80				
Right Rotation			80				

Consent to Treatment obtained? ☐ Yes ☐ No

If YES, when? ____________________

Tests	L	R
Balance Scale		
Dynanometer		
Pronation		
pH Test		
Zinc		
AK	**Mild**	**Mod**
Wheat		
Gluten		
Yeast		
Dairy		
Sugar		
Caffeine		
Vitals	**L**	**R**
BP		
Pulse		
Choles		
Blood Type		

Clinical Notes:

Red Flags:

Orthopaedic & Neurological:

Chiropractic Diagnosis & Impression/ Prognosis:

SHORT TERM ____________________

LONG TERM ____________________