

Name:		Cell Phone:	
Address:		Home Phone:	
City:	Prov:	Work Phone:	
Postal Code:	Gender: F / M / O	Birth Date: D/M/Y	Age:
Email:		School grade level:	
Parents/Guardians Names (1)		(2)	
Phone (1):		(2)	
Email (1):		(2)	
Health Insurance Company & coverage amount/year:			
Name of Family Doctor:		Date of last physical:	

List Exercises – Sports - Interests:

Would you like appointment reminders by: Email SMS (text)

List any allergies:

How did you hear about our office? _____

Have you had previous Chiropractic care? No Yes If yes, when was your last visit: _____

Indicate your primary symptom: _____

Is your symptom due to an accident or a fall? No Yes describe: _____

When did your symptom begin? _____ Have you had this symptom before? No Yes

What do you think caused your symptom? _____

Have you had previous treatment for this symptom? No Yes, specify _____

Have you had X-ray, MRI or other tests for this symptom? No Yes, specify: _____

Does this symptom interfere with your: school work sleep mood activities family life

Rate the intensity of your symptom 1 2 3 4 5 6 7 8 9 10
Least pain Worst pain

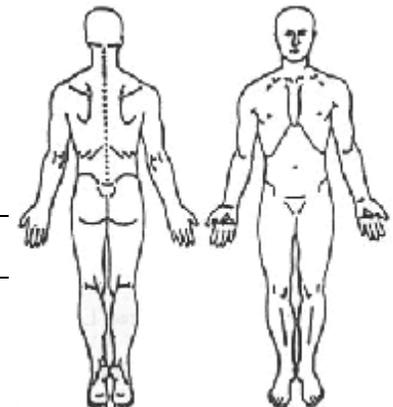
Is your symptom: Constant Occasional Worse in the morning at night

What aggravates your symptom? _____

What relieves your symptom? _____

Indicate on the diagram (to the right): S for SHARP Pain D for DULL pain

T for TINGLING/NUMBNESS B for BURNING/ THROBBING A for ACHING pain



Please check the following boxes: **“C”** for the conditions you are **CURRENTLY** experiencing and under the **“P”** for conditions you have had in the **PAST** **** the last row in italics are for females only ****

C P	C P	C P	C P
Unexplained weight loss <input type="checkbox"/> <input type="checkbox"/>	Slurred speech <input type="checkbox"/> <input type="checkbox"/>	Poor appetite <input type="checkbox"/> <input type="checkbox"/>	Headaches <input type="checkbox"/> <input type="checkbox"/>
Unrelenting pain (day or night) <input type="checkbox"/> <input type="checkbox"/>	Previous stroke/ TIA <input type="checkbox"/>	Fever / chills/ sweats <input type="checkbox"/> <input type="checkbox"/>	Jaw pain <input type="checkbox"/> <input type="checkbox"/>
Loss of bowel/bladder function <input type="checkbox"/> <input type="checkbox"/>	Double vision <input type="checkbox"/> <input type="checkbox"/>	Frequent colds <input type="checkbox"/> <input type="checkbox"/>	Sinus pain <input type="checkbox"/> <input type="checkbox"/>
Loss of balance/ feel unstable <input type="checkbox"/> <input type="checkbox"/>	Heart palpitations <input type="checkbox"/> <input type="checkbox"/>	Ear infection <input type="checkbox"/> <input type="checkbox"/>	Neck pain <input type="checkbox"/> <input type="checkbox"/>
Poor concentration or memory <input type="checkbox"/> <input type="checkbox"/>	Fainting / dizziness <input type="checkbox"/> <input type="checkbox"/>	Heartburn/indigestion <input type="checkbox"/> <input type="checkbox"/>	Upper/Mid Back <input type="checkbox"/> <input type="checkbox"/>
Ear pain/ ringing <input type="checkbox"/> <input type="checkbox"/>	Chest pain <input type="checkbox"/> <input type="checkbox"/>	Constipation/Diarrhea <input type="checkbox"/> <input type="checkbox"/>	Shoulder pain <input type="checkbox"/> <input type="checkbox"/>
Spitting up phlegm/ blood <input type="checkbox"/> <input type="checkbox"/>	High blood pressure <input type="checkbox"/> <input type="checkbox"/>	Irritable bowel <input type="checkbox"/> <input type="checkbox"/>	Wrist/hand pain <input type="checkbox"/> <input type="checkbox"/>
Difficulty swallowing <input type="checkbox"/> <input type="checkbox"/>	Low blood pressure <input type="checkbox"/> <input type="checkbox"/>	Nausea / vomiting <input type="checkbox"/> <input type="checkbox"/>	Low Back pain <input type="checkbox"/> <input type="checkbox"/>
Cold hands or feet <input type="checkbox"/> <input type="checkbox"/>	Tremors <input type="checkbox"/> <input type="checkbox"/>	Asthma <input type="checkbox"/> <input type="checkbox"/>	Hip/Groin pain <input type="checkbox"/> <input type="checkbox"/>
Swollen hands or feet <input type="checkbox"/> <input type="checkbox"/>	Difficulty breathing <input type="checkbox"/> <input type="checkbox"/>	Anxiety/ depression <input type="checkbox"/> <input type="checkbox"/>	Knee pain <input type="checkbox"/> <input type="checkbox"/>
Painful urination <input type="checkbox"/> <input type="checkbox"/>	Chronic cough <input type="checkbox"/> <input type="checkbox"/>	Difficulty sleeping <input type="checkbox"/> <input type="checkbox"/>	Ankle/arch pain <input type="checkbox"/> <input type="checkbox"/>
Blood in urine/ stool <input type="checkbox"/> <input type="checkbox"/>	Bronchitis <input type="checkbox"/> <input type="checkbox"/>	Pneumonia <input type="checkbox"/> <input type="checkbox"/>	Migraines <input type="checkbox"/> <input type="checkbox"/>
<i>Menstrual pain</i> <input type="checkbox"/> <input type="checkbox"/>	<i>Irregular cycles</i> <input type="checkbox"/> <input type="checkbox"/>	<i>Mood swings</i> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Indicate any other conditions of concern: _____

Please check all stressors you are currently

Prolonged sitting <input type="checkbox"/>	Poor sleep <input type="checkbox"/>	Prolonged standing <input type="checkbox"/>	Repetitive twisting <input type="checkbox"/>
Emotional stress <input type="checkbox"/>	Poor posture <input type="checkbox"/>	Repetitive lifting <input type="checkbox"/>	<input type="checkbox"/>
Fell /jumped from a height greater than 4 ft (e.g. play structure/ bunk bed) <input type="checkbox"/>	Had an impacts snowboarding/ skiing/ biking /trampoline etc.... <input type="checkbox"/>	Play contact sports <input type="checkbox"/>	Dropped as a baby/child <input type="checkbox"/>
History of concussion <input type="checkbox"/>	Fractured a bone <input type="checkbox"/>	Received stitches <input type="checkbox"/>	Had surgery <input type="checkbox"/>
Had a sport's injury <input type="checkbox"/>	Sprained an ankle <input type="checkbox"/>	Had a serious fall <input type="checkbox"/>	Had emergency care <input type="checkbox"/>

Describe any major trauma or impact: _____

List any diagnosed condition(s): _____

List any medication you are currently taking: _____

List intake

Hours of sitting _____ /day	Glasses of water: _____ /day	Caffeinated drinks: _____ /day	Food Intolerance/List:
Screen time: _____ hrs/ day	Hours of sleep: _____ /night	Hours of exercise: _____ /week	

The fee for the New Patient Consultation and examination is 95\$. X-ray digital imaging if required is 40\$ - 80\$.

Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature: _____ Date: _____

Informed Consent to Chiropractic Care

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscles and ligament strains and sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do 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 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 skin irritation/ bruising with the use of some types of instrument or therapy offered by some doctors of chiropractic.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that association with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care in this office.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Name: _____
(please print)

Witness of Signature

Name: _____
(please print)