Clarity Chiropractic

INITIAL CONSULTATION FORM (ADULT)

PERSONAL INFORMATION Today's Date (M/D/Y) _____

Name _____ (M / F) Birth Date (M/D/Y) _____ Age _____

Phone (please circle preferred contact) H _____ W _____ C _____

Address _____ City _____ Province _____ Postal Code _____

Email _____ Height _____ Weight _____

Occupation _____ Employer _____

Marital Status (S / M / W / D / CLaw) # of Children: ____ Significant others name: _____

Child/children's name(s) and age(s):

Referred to this office by _____ Insurance other than OHIP? _____

CURRENT HEALTH COMPLAINT(S)

Please share with us the conditions or symptoms that have brought you into our office. If you have any questions about how to answer this section, please let us know. If this is for a wellness or spine checkup, please mark here [ ].

	1	2	3
Health Issue:			
Believed Cause:			
Severity (1-10):			
How Long:			
Previous Care (Y/N):			

How significantly have these conditions/symptoms effected your family, work, and leisure life (1-10)? _____

On a scale of 0-10 what is your commitment to correcting these problems (0 being none, 10 being full)? _____

Were any of these caused by a motor vehicle accident (MVA) or work related injury? (Please circle) Yes / No

Have you had any time loss from work for this? (If recent, list dates) Yes / No _____

LIFESTYLE

Please rate the following on a scale of 0-10 (0 being none, 10 being high)

Fatigue: ____ Stress (Work): ____ Stress (Personal): ____ Quality of sleep: ____

Exercise Y / N _____ days per week Alcohol Y / N _____ drinks per week

Coffee or Tea Y / N _____ cups per day Junk or Fast Food Y / N _____ times per week

Tobacco Y / N _____cigarettes per day

List any vitamins, supplements and/or minerals you are currently taking _____

List any medication or drugs you are currently taking and the reason you are taking them below

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HEALTH HISTORY FORM

Please check if you suffer from, previously suffered from, or are concerned you suffer from any of the following;

Musculoskeletal
Headaches ____
Arthritis ____
Neck pain ____
Back pain ____
Low back pain ____
Sciatica ____
Shoulder pain ____
Elbow/arm/wrist pain ____
Hip pain ____
Knee pain ____
Shin/ankle pain ____
Osteoporosis ____
Other _____

Digestive
Constipation ____
Diarrhea ____
Incontinence ____
Other _____

Cardiac
Heart attack ____
High/low blood pressure ____
Stroke ____
High cholesterol ____
Aneurysm ____
Angina ____
Other _____

Respiratory
Pneumonia ____
Asthma ____
Pleurisy ____
Sinus conditions ____
Other _____

Other
Fatigue ____
Cancer ____
Diabetes ____
Erectile dysfunction ____
Skin conditions ____
Chronic flu/colds ____
Epilepsy ____
Visual challenges
Allergies ____
STI's ____
Hearing problems ____
Psoriasis ____
Hepatitis ____
Other _____

Women's Health
Ovarian cysts ____
PMS symptoms ____
Painful menstruation ____
Irregular menstruation ____
Other _____

Falls and Accidents _____

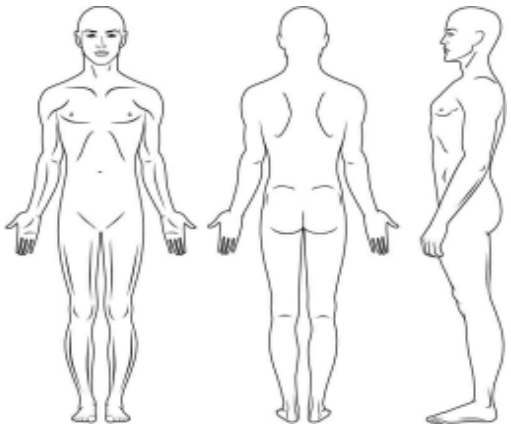
All Surgery and Operations _____

Surgery recommended but not performed _____

Family health conditions or problems (please list) _____

In the diagrams provided, please mark the areas of your body that you feel best represent the discomfort(s) or sensation(s) you are experiencing.
Use the symbols provided below.

Numbness:	/ / / /
Burning:	x x x
Dull and aching:	+ + +
Pins and needles:	* * *
Sharp and stabbing	= = =
Stiff and tight	2 2 2



Signature: _____ Date: _____

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Informed Consent for 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:

While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic care, including spinal adjustment, has been the subject of government reports and multi-disciplinary 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 associated 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.

Dated this _____ day of _____, 20_____.

_____
Patient Signature (Guardian)

Name: _____
(please print)

_____
Witness of Signature

Name: _____
(please print)

Clarity Chiropractic

Consent for Use or Disclosure of Health Information

We, at the Clarity Chiropractic, are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.
We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, and/or treatment of your health condition.
We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
We may need to use your health information within our practice for quality control or other internal operational purposes.

You have the right to request that we do not disclose your health information to specific individuals, companies, and/or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

You may revoke any of your authorization at any time; however, your revocation must be in writing. We will not be able to honour your revocation request if we have already released your health information before we receive your request to revoke your authorization.

I have read your consent policy and agree to its terms.
I am requesting a copy of this consent form [ ]
I am not requesting a copy of this consent form [ ]

_____ _____

Signature of Patient Signature of Witness

_____ _____

Date Date