

Temple Crossing Chiropractic and Massage
204 – 5401 Temple Drive NE

(403) 280-8992

Outline of Procedure for New Practice Members

1. STEP ONE:

All new patients are requested to fill out a personal health/history questionnaire

2. STEP TWO:

Your first consultation with the doctor to discuss your health problems.

3. STEP THREE:

Chiropractic examination and Orthopedic and Neurological examinations as related to chiropractic to determine chiropractic care for you.

4. STEP FOUR:

The doctor will advise you as to the need of additional procedures such as X-Ray tests if necessary.

5. STEP FIVE:

You will be given a “*Report of Findings*”. The doctor will inform you as to your examination results. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

6. STEP SIX:

After you receive you report of findings, your recommended course of care will be explained to you.

7. STEP SEVEN:

Adjustments will begin and continue as scheduled until maximum correction for you has been obtained.

8. STEP EIGHT:

A re-evaluation to quantify your spinal health progress will be completed and you care program may be modified.

9. STEP NINE:

After maximum correction, a schedule of wellness care will be recommended.

PERSONAL HISTORY

Dear Practice Member:

Please complete this questionnaire. Your answers will help determine if Chiropractic can help you. Please answer ALL questions, even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unaware of. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name: _____ Date: _____ Sex: _____

A.H.C. Ins. No. _____ Phone: Home _____ Office _____ Cell _____

Address _____ Postal Code _____

Marital Status: _____ Age: _____ Weight: _____ Height: _____ Children _____

Birthdate: _____ Birthplace: _____ Occupation: _____

Employer: _____ Family M.D. _____

Referred to this office by: _____ Email address: _____

Who is responsible for your bill? Self Spouse Parent or Guardian Other _____

Third Party Insurance (London Life, Great West, Blue Cross, etc.) _____

CURRENT HEALTH CONDITION

Present Complaint: _____

Have you had any previous treatment for this condition? _____

When did this condition begin? _____

Are there others in you family with this same condition? _____

Have you had any time loss from work for this condition? (If recent list dates) _____

Is this a WCB Case? _____ If yes-SIN and date of accident _____

Are you presently taking medication? (please mention) _____

When is the last time you really felt well? _____

How important is your health to you on a scale of 1 – 10, 10 being the most important? _____

PAST HEALTH HISTORY

Major surgery/operations: Appendix Tonsils Gall Bladder Hernia
 Heart Back Neck Leg Other _____

Major accidents or falls: (please describe) _____

Previous Chiropractic Care : Doctor's name and approximate date of last visit _____

Have you been treated for any health condition in the last year? Yes No

If yes, please explain _____

Check any conditions which are presently causing you a problem.
Please underline which were a problem in the past.

GENERAL

- headache
- numbness or pain in arms or legs
- dizziness
- ringing in ears
- whiplash
- fainting
- earache
- sore throat
- nose bleeds
- sinus problems
- asthma
- enlarged glands
- loss of weight
- hypoglycemia
- nervousness
- depression/confusion
- vision problems
- dental problems
- hearing problems

ORGANS

- frequent urination
- painful urination
- blood in urine
- bladder trouble
- kidney stones
- bed wetting
- prostate problems
- sexual dysfunction
- anemia
- thyroid
- excessive appetite
- gas/bloating
- nausea or vomiting
- constipation/diarrhea
- colitis
- black/bloody stool
- hemorrhoids
- liver trouble
- gall bladder trouble

SKIN

- eczema
- skin eruptions
- varicose veins

MUSCLE & JOINT

- low back problems
- neck problems
- sore joints
- painful tailbone
- pain between shoulders
- arthritis
- sore muscles
- walking problems
- broken bones
- difficulty chewing/ clicking jaw
- ankle swelling

RESPIRATORY & HEART

- lung problems
- chronic cough
- spit up blood
- frequent colds/flu
- shortness of breath/ difficult breathing
- heart problems

FEMALES ONLY

- painful periods
- irregular cycle
- cramps, backache
- vaginal discharge/infection
- lumps/pain in breast
- menopausal symptoms
- previous miscarriage
- unable to get pregnant
- hot flashes
- Birth Control?
- are you pregnant?
- yes no not sure
- when was your last period?

Check any of the following diseases you have had:

- alcoholism
- epilepsy
- sexually transmitted diseases
- stroke
- arthritis
- hypoglycemia
- tuberculosis
- rheumatic fever
- diabetes
- cancer
- allergies
- heart disease

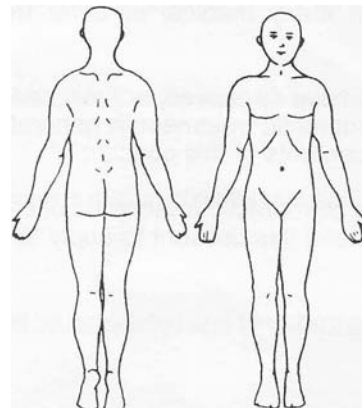
Has anyone in your family had any of the following diseases?

- heart disease
- high blood pressure
- cancer
- stroke
- arthritis

HABITS

	None	Light	Moderate	Heavy
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Junk Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please outline on the diagram the area of your discomfort.



Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (**Wellness**). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, this prepared recommendation is in incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief/Initial intensive care Corrective/Rehabilitative care Wellness/Maintenance care

Check here if you want the doctor to select the type of care appropriate for your condition.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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 adjustments is extremely remote.

c. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has ever 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 in association 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 or my condition, and the contents of the Consent. I consent to the chiropractic treatments 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.

Dated this _____ day of _____, 20____.

Patient Signature (Legal Guardian)

Witness of signature

Name: _____
(please print)

Name: _____
(please print)