WELCOME

TO THE

BURLINGTON NATURAL HEALTH CENTRE

PLEASE FILL IN THESE FORMS AS COMPLETELY AS POSSIBLE. THANKYOU!

NAME _____ **DATE** _____

ADDRESS _____ **Gender** _____

CITY, PROVINCE _____ **POSTAL CODE** _____

HOME PHONE _____ **E MAIL** _____

DATE OF BIRTH (D/M/Y) _____ **AGE** _____ **MARITAL STATUS** _____

SPOUSE'S NAME _____ **# CHILDREN** _____

OCCUPATION _____

EMPLOYER _____ **PHONE** _____

ADDRESS _____

OHIP # & LETTER CODE _____ **EXP. DATE:** _____

EXTENDED HEALTH CARE COMPANY _____

POLICY # _____

EMERGENCY CONTACT _____ **RELATION** _____

HOW DID YOU HEAR ABOUT OUR OFFICE _____
(IF REFERRED, BY WHO?)

ARE YOU HERE BECAUSE OF A: **MOTOR VEHICLE ACCIDENT** **YES** **NO**

WORK RELATED ACCIDENT **YES** **NO**

PRIOR CHIROPRACTIC CARE: **NAME** _____ **PHONE** _____

WHEN _____ **X – RAYS TAKEN** **YES** **NO**

RESULTS _____

MEDICAL DOCTOR: **NAME** _____ **PHONE** _____

DATE OF LAST VISIT _____

Dr. David Walsh, 1066 Brant Street, Burlington, ON L7R 2J9 905 634 8598

CURRENT HEALTH CONDITION(S)

BNHC 1066 Brant Street, Burlington, ON L7R 2J9

CURRENT COMPLAINT(S) _____

_____

HOW DID THIS CONDITION BEGIN _____

DATE OF ONSET _____ HAS IT OCCURRED BEFORE □ YES □ NO

WHAT AGGRAVATES YOUR CONDITION □ SITTING □ STANDING □ BENDING □ LIFTING □ WALKING

□ LYING □ COLD □ DAMPNESS □ OTHER _____

WHAT RELEIVES YOUR CONDITION □ BED REST □ ICE □ HEAT □ MASSAGE □ MEDICATION

□ OTHER _____

IS THE PAIN □ CONSTANT □ INTERMITTENT □ WORSENING □ IMPROVING

TYPE OF PAIN □ SHARP □ DULL □ ACHE □ PINS & NEEDLES □ NUMB □ BURNING □ SHOOTING

□ OTHER _____

TO WHAT DEGREE DOES THE PAIN HAMPER YOUR ABILTY TO (1 Not at all, 10 Completely)

WORK 1 _____ 10

ENJOY FAMILY / SOCIAL LIFE 1 _____ 10

ENJOY HOBBIES / SPORTS 1 _____ 10

OTHER DOCTORS SEEN FOR *THIS* CONDITION □ YES □ NO WHO _____

TYPE OF TREATMENT _____ RESULTS _____

DRUGS YOU NOW TAKE □ NERVE PILLS □ PAIN KILLERS □ MUSCLE RELAXERS □ BLOOD PRESSURE

□ INSULIN □ OTHER _____

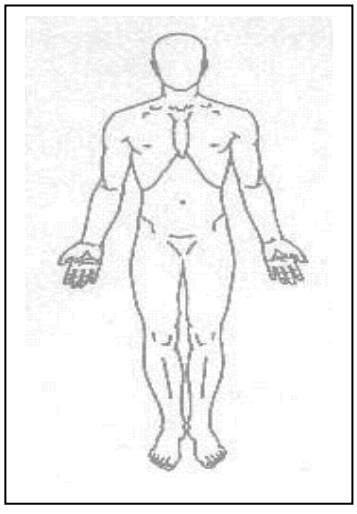
DO YOU SUFFER FROM ANY OTHER CONDITION OTHER THAN THAT FOR WHICH YOU ARE NOW CONSULTING US?

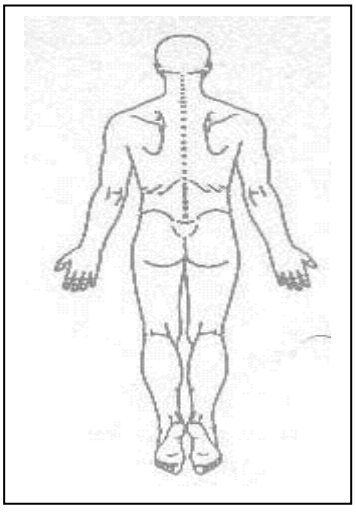
_____

PLEASE COMPLETE THE FOLLOWING DIAGRAMS

1. DRAW IN YOUR FACE
2. CIRCLE AREAS OF PAIN
3. USE THE FOLLOWING SYMBOLS

Pins & Needles	0 0 0 0 0 0 0 0	Radiation
Numbness	x x x x x x x x	
Burning	/ / / / / / / / / /	
Aching	s s s s s s s s	
Stabing	· · · · · · · ·	





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PAST HEALTH HISTORY

SURGERY / OPERATIONS _____

_____

MAJOR ACCIDENTS / INJURIES _____

_____

HOSPITALIZATION (Other than above) _____

_____ **PREVIOUS X - RAYS** _____

FAMILY HEALTH CONDITIONS OR PROBLEMS _____

_____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD

☐ Aneurysm	☐ Osteoporosis	☐ Diabetes	☐ Arthritis	☐ Respiratory Conditions
☐ Epilepsy	☐ Cancer	☐ Strokes	☐ Allergies	☐ Heart Conditions
☐ Hepatitis	☐ Fatigue	☐ Polio	☐ Pneumonia	☐ Sleeping Difficulty
☐ Pleurisy	☐ Asthma	☐ V.D.	☐ Psoriasis	☐ HIV

OTHER HEALTH CONDITIONS _____

_____

PLEASE CHECK ANY OF THE SYMPTOMS YOU HAVE OR HAVE HAD

GENERAL
☐ Allergy
☐ Chills
☐ Convulsions
☐ Dizziness
☐ Fainting
☐ Fevers
☐ Headaches
☐ Loss of Sleep
☐ Nervousness
☐ Depression
☐ Neuralgia
☐ Numbness
☐ Sweats
☐ Weight Loss
☐ Tremors

WOMEN ONLY
☐ Cramps ☐ Irregular Cycle ☐ Painful Cycle
☐ Heavy Flow ☐ Light Flow ☐ Discharge
☐ Sore Breasts Menopausal : ☐ Yes ☐ No Since_____
Pregnant: ☐ Yes ☐ No Due Date_____

MUSCLE&JOINT
☐ Bursitis
☐ Foot Trouble
☐ Hernia
☐ Low Back Pain
☐ Neck Pain
☐ Neck Stiffness
☐ Shoulder Pain

SKIN
☐ Varicose Veins
☐ Boils
☐ Bruise Easily
☐ Dryness
☐ Hives / Allergy
☐ Itching
☐Rashes

RESPIRATORY
☐ Chest Pain
☐Chronic Cough
☐ Hard To Breath
☐ Spitting Blood
☐ Throat Phlegm
☐ Wheezing

GENITOURINARY
☐ Smell of Urine
☐ Bed Wetting
☐ Blood in Urine
☐ Frequent Urine
☐ Bladder Control
☐ Kidney Infection
☐ Painful Urination
☐ Prostate Trouble
☐ Pus in Urine

EENT
☐ Colds
☐ Crossed Eyes
☐ Deafness
☐ Dental Decay
☐ Asthma
☐ Ear Aches
☐ Ear Discharge
☐ Ear Noises
☐ Sinus Infections
☐ Enlarged Glands
☐ Enlarged Thyroid
☐ Sore Throats
☐ Tonsillitis
☐ Eye Pain
☐ Failing Vision
☐ Far Sighted
☐ Gum Trouble
☐ Hay Fever
☐ Hoarseness
☐ Nasal Obstruction
☐ Near Sighted
☐ Nosebleeds

CARDIO-VASCULAR
☐ Rapid Heart Beats
☐ Slow Heart Beats
☐ Ankle Swelling
☐ Hardening of Arteries
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Pain Over Heart
☐ Poor Circulation

PAIN OR NUMBNESS
☐ Head
☐ Shoulders
☐ Arms
☐ Hands
☐ Hips
☐ Legs
☐ Knees
☐ Ankles
☐ Feet
☐ Tail Bone
☐ Sciatica
☐ Swollen Joints

DO YOU SMOKE ☐Yes ☐No DO YOU CONSUME ALCOHOL ☐Yes ☐No DO YOU EXERCISE ☐Yes ☐No

CONSENT TO CHIROPRACTIC TREATMENT

Burlington Natural Health Centre
Dr. David Walsh
1066 Brant Street, Burlington, Ontario L7R 2J9
905-634-8598

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.
Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.
- Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
- The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.
The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives
Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

Initial Examination

I hereby consent to an initial examination by the Chiropractor and understand that some procedures may cause immediate and/or temporary lasting discomfort. I have the right to ask questions and/or ask that the examination be terminated at anytime. The examination procedures are commonly accepted practices with very low risk, however, the practitioner can not be expected to predict all potential effects.

Please initial here that you have read the above _____
Initial above

PLEASE SIGN AND CONSULT WITH THE CHIROPRACTOR IF YOU HAVE ANY QUESTIONS

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____ _____
Patient's Name Patient's Signature

_____ _____
Date Witness