Dr. Gary Malstrom B.Sc.(Hon.), D.C., C.Ac.
1066 Brant Street, Burlington, Ontario L7R 2J9 (905) 681-3342 Fax (905) 634-4875

Personal History:

Name:________________________________ Address:______________________________________
City:___________________________________ Province:______________ Postal Code:____________
Birth date: *day*_________*/month*_________*/year*_________ Age:________ Sex: M□ F□
Home Phone:__________________________
Business Phone:_______________ Cell Phone:________________ E-mail:________________________
Health Card:______________________ Version Code:_____ Employer:____________________________
Name of Family Physician:________________________
Who may we thank for referring you to our office?____
How will you be paying your account? VISA□ Debit□ Cash□ Cheque□

Current Health Condition:

Current Complaint(s):____
Have you seen other doctors for this condition? Yes□ No□
Who?_____________________________________
Type of treatment:___________________________ Results:_________________________________
When did this condition begin:__________________ Has it occurred before? Yes□ No□
Is this condition the result of an injury: Yes□ No□
If 'Yes', what type of injury? Work□ Auto□ Sports□ Fall□ Other___________________________
Date of accident/injury:________________________
What aggravates your condition? Sitting□ Standing□ Bending□ Lifting□ Walking□
Lying Down□ Dampness□ Cold□ Other_____________________
What relieves your condition? Bed rest□ Massage□ Heat□ Ice□ Medication□
Other____________________________
Is this condition: Getting worse□ Constant□ Intermittent□ Getting better□
Character of the pain: Sharp□ Dull□ Ache□ Pins & Needles□ Numb□ Burning□
Place an X on the grade to indicate the severity of your pain:
least 1 2 3 4 5 6 7 8 9 10 *worst*
Does this problem interfere with: Work□ Family or social time□ Hobbies or sports□
If you don't get the problem corrected do you think it will get worse over the next 5 years? Yes□ No□
Medications you are currently taking: Painkillers□ Muscle Relaxants□ Blood Thinners□ Insulin□
Anti-inflammatories□ Blood Pressure Medication□
Anti-depressants□ Birth Control Pills□ Steroid Medications□
Other ____
Have you had x-rays related to this condition in the past year? Yes□ No□
If yes, where?____
Previous: Childhood Traumas□______________________ Sports Injuries□________________________
Motor Vehicle Accidents□_________________ Work Injuries□__________________________
Previous Chiropractic Care: Yes□ No□ When?:__________________
Results:____
List previous surgeries and year:____

Dr. Gary Malstrom B.Sc.(Hon.), D.C., R.Ac.
1066 Brant Street, Burlington, Ontario L7R 2J9 (905) 681-3342 Fax (905) 634-4875

Health Review:

Below is a list of diseases or conditions which may seem unrelated to the purpose of your appointment, however these questions must be answered carefully as these problems can affect your overall course of chiropractic care.
Are you ***currently*** experiencing, or have you ***previously*** experienced any of the following conditions.
Check ***all*** that apply:

General:	*Current:*	*Previous:*	*Neurological:*	*Current:*	*Previous:*
Recent surgery	□	□	Migraine	□	□
Loss of appetite	□	□	Vision problems	□	□
Bruise/bleed easily	□	□	Numbness	□	□
Frequent infections	□	□	Tingling extremities	□	□
Weight loss	□	□	Nervousness	□	□
Fatigue	□	□	Dizziness	□	□
Fever	□	□	Depression	□	□
Loss of sleep	□	□	Forgetfulness	□	□
Anemia	□	□	Fainting	□	□
Stress	□	□	Convulsions	□	□

Musculo-skeletal:	*Current:*	*Previous:*	*Gastro-intestinal:*	*Current:*	*Previous:*
Headaches	□	□	Excessive thirst	□	□
Jaw pain	□	□	Heart burn	□	□
Neck pain	□	□	Frequent nausea	□	□
Pain between shoulders	□	□	Abdominal cramps	□	□
Arm pain	□	□	Vomiting	□	□
Mid back pain	□	□	Diarrhea	□	□
Low back pain	□	□	Constipation	□	□
Leg pain	□	□	Hemorrhoids	□	□
Joint pain/stiffness	□	□	Weight trouble	□	□
Walking problems	□	□			

Female:	*Current:*	*Previous:*	*Male:*	*Current:*	*Previous:*
Menstrual irregularities	□	□	Bladder trouble	□	□
Menstrual cramping	□	□	Prostate problems	□	□
Breast pain/lumps	□	□	PSA test	□ Yes	□ No
Are you pregnant	□Yes □No	□Don't know			

When was your last period?______________________

Do you or have you suffer(ed) from any of the following health conditions?

□Arthritis	□Fractures	□Cancer
□Heart disease	□Liver disease	□Lung disease
□Stroke	□Asthma	□Parkinson's disease
□M.S.	□Fibromyalgia	□Diabetes
□Gall bladder disease	□Alzheimer's disease	□Chronic Fatigue Syndrome

□Other____

Dr. Gary Malstrom B.Sc.(Hon.), D.C., R.Ac.

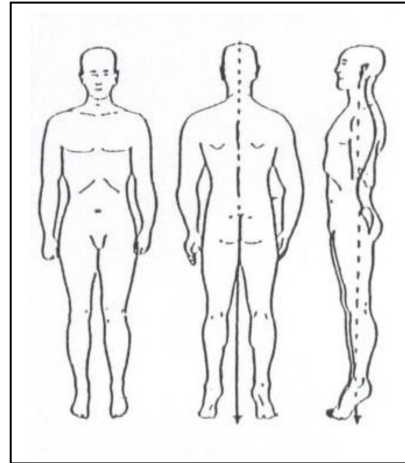
1066 Brant Street, Burlington, Ontario L7R 2J9 (905) 681-3342 Fax (905) 634-4875

Health Review Continued:

Do you: Drink Alcohol □ Smoke □
Do you exercise regularly? Yes □ No □

Satisfaction With Diet:
□ Satisfied
□ Somewhat Satisfied
□ Dissatisfied

Lifestyle Stress Level:
□ High
□ Moderate
□ Little



Please outline on the diagram the area of your discomfort and any radiation of pain

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition, (Relief Care), while others are interested in having the cause of the problem as well as the symptoms corrected and relieved, (Corrective Care). Still others have ongoing chronic conditions which can be managed by Maintenance Care. These are the three phases of care. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:
□ Maintenance Care (care for chronic conditions)
□ Corrective Care (removing cause of a recurrent condition)
□ Relief Care (pain reduction)

Please read carefully:
I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that the Doctor’s office will prepare any necessary reports and forms to assist me in making collection from my insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and are payable in full immediately following the service unless other arrangements have been agreed to in writing. I also understand that if I suspend or terminate care at this office, any outstanding charges for professional services rendered to me will be immediately due and paid in full.

I hereby request and consent to the performance of a chiropractic examination and other chiropractic procedures including various modes of physical therapy and if necessary diagnostic x-rays on me by the Doctor of Chiropractic and/or anyone working in this clinic authorized by the Doctor of Chiropractic. This consent is valid for any future conditions for which I may seek care. I may ask any questions to the Doctor either before or after I sign this consent and I understand that consent can be withdrawn in writing at any time.

____ _________________________
Patient Signature Date

CONSENT TO CHIROPRACTIC TREATMENT

Burlington Natural Health Centre
Dr. Gary Malstrom, D.C., C.Ac.
1066 Brant Street, Burlington, Ontario L7R 2J9
905-681-3342

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