



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 _____



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 DAMPNES OTHER _____

WHAT RELIEVES 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 ABILITY 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 _____

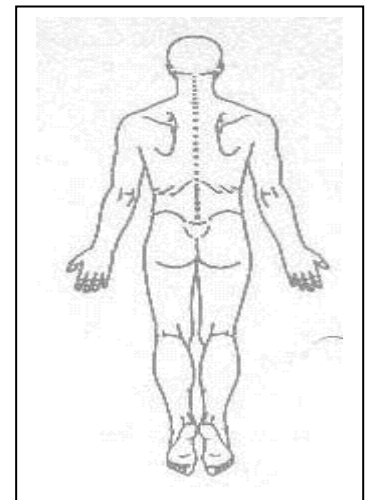
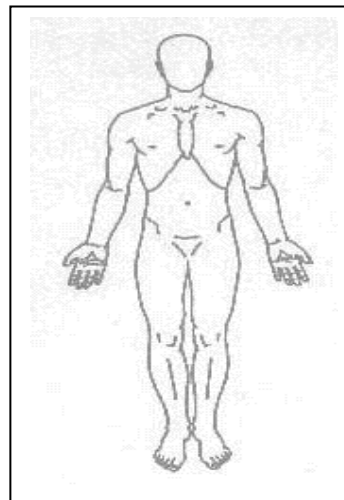
DRUGS YOU NOW TAKE NERVE PILLS PAIN KILLERS MUSCLE RELAXERS BLOOD PRESSURE
 INSULIN OTHER _____

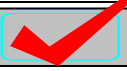
DO YOU SUFFER FROM ANY OTHER CONDITION OTHER THAN THAT FOR WHICH YOU ARE NOW CONSULTING US?

PLEASE COMPLETE THE FOLLOWING DIAGRAMS

- DRAW IN YOUR FACE
- CIRCLE AREAS OF PAIN
- USE THE FOLLOWING SYMBOLS

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





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

- | | | | | |
|------------------------------------|---------------------------------------|-----------------------------------|------------------------------------|---|
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Respiratory Conditions |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Strokes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Conditions |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Polio | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sleeping Difficulty |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Asthma | <input type="checkbox"/> V.D. | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> HIV |

OTHER HEALTH CONDITIONS _____

PLEASE CHECK ANY OF THE SYMPTOMS YOU HAVE OR HAVE HAD

- | | | | | |
|--|--|--|--|--|
| <u>GENERAL</u> | <u>MUSCLE&JOINT</u> | <u>RESPIRATORY</u> | <u>EENT</u> | <u>CARDIO-VASCULAR</u> |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Colds | <input type="checkbox"/> Rapid Heart Beats |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Slow Heart Beats |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hard To Breathe | <input type="checkbox"/> Deafness | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Spitting Blood | <input type="checkbox"/> Dental Decay | <input type="checkbox"/> Hardening of Arteries |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Throat Phlegm | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shoulder Pain | <u>GENITOURINARY</u> | <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Pain Over Heart |
| <input type="checkbox"/> Loss of Sleep | <u>SKIN</u> | <input type="checkbox"/> Smell of Urine | <input type="checkbox"/> Ear Noises | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Sinus Infections | <u>PAIN OR NUMBNESS</u> |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Boils | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Head |
| <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Urine | <input type="checkbox"/> Enlarged Thyroid | <input type="checkbox"/> Shoulders |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Dryness | <input type="checkbox"/> Bladder Control | <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Arms |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Hives / Allergy | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Hands |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Itching | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Rashes | <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Failing Vision | <input type="checkbox"/> Legs |
| WOMEN ONLY | | <input type="checkbox"/> Pus in Urine | <input type="checkbox"/> Far Sighted | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Irregular Cycle | | <input type="checkbox"/> Gum Trouble | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Heavy Flow | <input type="checkbox"/> Light Flow | | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Sore Breasts | <input type="checkbox"/> Discharge | | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Tail Bone |
| <input type="checkbox"/> Menopausal : <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Since _____ | | <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Due Date _____ | | <input type="checkbox"/> Near Sighted | <input type="checkbox"/> Swollen Joints |
| | | | <input type="checkbox"/> Nosebleeds | |

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. Anthony Adams
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