

**WALKER
HEALTH FACILITY
LIMITED**

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CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Date: _____

Name: _____

Address: _____ Postal Code: _____

Date of Birth: _____ Age: _____ Sex: M ___ F ___ Marital Status: M ___ S ___ D ___ W ___

Partner's Name: _____ No. of Children & Ages: _____

Occupation: _____ Employer: _____

Home Phone #: _____ Cell Phone #: _____ Business Phone #: _____

E-mail Address _____

Have you had previous chiropractic care? _____

Where? _____ When? _____

Why? _____ Were x-rays taken? _____

How did you hear of this office? _____

PRESENT REASON FOR CONSULTING THIS OFFICE:

(Please check one of the following)

___ I have a problem and I am interested in help with this specific problem. In addition I am interested in learning about my Health Potential and the role of "WELLNESS" in improving my own and my family's health.

___ I have a problem and I am interested in help with this specific problem and in learning how to prevent it in the future.

___ I have a problem and I am only interested in help with this specific problem.

Purpose of your appointment: _____

How long have you had this condition? _____

Is this condition getting worse? Yes ___ No ___ Constant ___ Varies ___

This condition interferes with Work ___ Sleep ___ Daily routine ___

List any previous diagnosis or treatment you have received for this or similar conditions in the past.

How long has it been since you really felt good? _____

Have you been involved in an auto accident? Yes ___ No ___

Past Year? ___ Past 5 Years? ___ Over 5 Years? ___

Name of Medical Doctor or Medical Clinic where you are a patient. _____

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Appendicitis
 Scarlet Fever
 Diphtheria
 Typhoid Fever
 Pneumonia
 Rheumatic Fever
 Polio

Malaria
 Tuberculosis
 Whooping Cough
 Anemia
 Measles
 Mumps
 Small Pox

Chicken Pox
 Diabetes
 Cancer
 Heart Disease
 Goiter
 Influenza
 Pleurisy

Alcoholism
 Venereal Disease
 Arthritis
 Epilepsy
 Mental Disorder
 Lumbago
 Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

Low back pain
 Pain between shoulders
 Neck pain
 Spinal curvature
 Arm pain
 Joint pain/stiffness
 Walking problems
 Difficulty chewing/clicking jaw
 Painful tailbone
 Hernia

NERVOUS CODE

Numbness
 Paralysis
 Dizziness
 Forgetfulness
 Confusion/Depression
 Fainting
 Convulsions
 Cold/Tingling extremities

GENERAL

Night sweats
 Allergies
 Loss of sleep
 Fever
 Headaches
 Asthma
 Fatigue
 Loss of weight

GASTRO-INTESTINAL

Poor/excessive appetite
 Excessive thirst
 Frequent nausea
 Vomiting
 Diarrhea
 Constipation
 Hemorrhoids
 Liver trouble
 Gall bladder trouble

Weight trouble
 Abdominal cramps
 Gas/bloating after meals
 Heartburn
 Black/bloody stool
 Colitis

GENITO-URINARY

Bed wetting
 Bladder trouble
 Painful/frequent urination
 Discoloured urine
 Blood in urine

CARDIOVASCULAR

Chest pain
 Shortness of breath
 Blood pressure problems
 Irregular heartbeat
 Heart problems
 Lung problems/congestion
 Varicose veins
 Ankle swelling

MALE/FEMALE

Hot flashes
 Menstrual irregularity
 Menstrual cramping
 Vaginal pain/infections
 Breast pain/lumps
 Prostate/Sexual dysfunction
 Genital herpes

SKIN

Itching
 Skin eruptions
 Dryness
 Bruise easily

EYES, EARS

NOSE & THROAT

Stuffed nose
 Hearing difficulties
 Frequent colds
 Vision problems
 Dental problems
 Sore throats
 Ear aches
 Sinus troubles
 Ringing in ears



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

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.

Name (Please Print)

Date: _____ 20____.

Signature of patient (or legal guardian)

Date: _____ 20____.

Signature of Chiropractor

Date: _____ 20____.