WALKER
HEALTH FACILITY
LIMITED

TODD J. WALKER, B.Sc., D.C.

177 Concession Street
Cambridge, Ontario
N1R 2H9
Tel: (519) 621-4567
Fax: (519) 621-8770

## 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._____

Age of your mattress: _____ Comfortable _____ Uncomfortable _____
Do you sleep on your stomach? _____

Are you wearing.....Heel lifts____ Sole lifts____ Inner soles_____ Arch supports_____

**MEDICATION** being used: Muscle Relaxers _____ Pain Killers _____ Nerve Pills _____
Vitamins _____ Insulin _____ Birth Control _____ Other _____

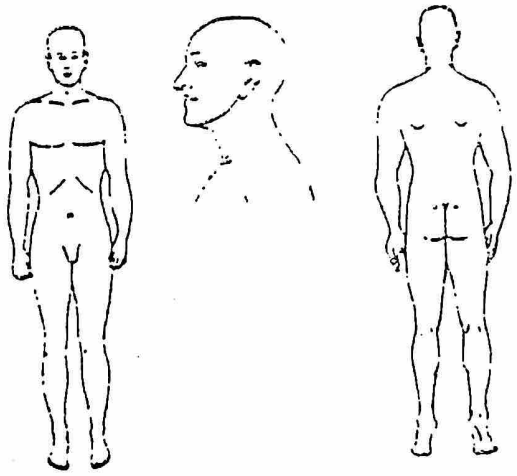
**FEMALES ONLY:**
Are you pregnant? _____ Date of your last menstrual period: _____

**SPINAL HISTORY**
List family members with spinal problems: _____
Have you ever been knocked unconscious? _____ Describe_____
Used a cane, crutch or other support? _____ Describe _____
Have you ever fractured a bone? _____ Describe_____

Please list any surgery you have had:
_____ Date:_____
_____ Date:_____
_____ Date:_____
_____ Date:_____

Mark the area on your body where you feel the described sensations. Use the appropriate symbols.

Numbness //////////
Pins and Needles oooooo
Burning xxxxxx
Stabbing +++++



**IF YOU ARE A WORKERS COMPENSATION PATIENT PLEASE PROVIDE THE FOLLOWING INFORMATION**

**COMPLETE** name and address of your employer:

_____
_____
_____
_____

Telephone No.: _____

S.I.N. _____ Date of Accident _____

## CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

__Appendicitis
__Scarlet Fever
__Diptheria
__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.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor