AHI - New Patient Information

Personal Information

Last Name	**First Name**	**Middle Initial**
Address: Street		**Unit #**
City	**Province**	**Postal Code**
Date of Birth (Day/Month/Year)		
Home Phone #	**Work Phone #**	**Cell Phone #**
May the clinic leave you messages relating to your visits? □**YES** □ **No**		
Email		
Employer		**Occupation**
Emergency Contact Name and Relationship		**Phone #**

How did you hear about the clinic? _____

Which members of the clinic will you be seeing?

□ **Chiropractor** □ **Physiotherapist** □ **Massage Therapist** □ **Naturopath** □**Personal Trainer**

Family Doctor
Name _____
Phone # _____
Fax # _____

Specialist
Name _____
Phone # _____
Fax # _____

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Health Information

What are your health concerns and/or reasons for coming to the clinic, in order or importance?

1. _____
2. _____
3. _____

What seems to make the condition better? _____

What seems to make the condition worse? _____

Has the condition; □ Gotten worse □ Gotten Better □ Stayed the same

Does the pain radiate or "shoot" anywhere? _____

Have you had this pain before? If yes, when? _____

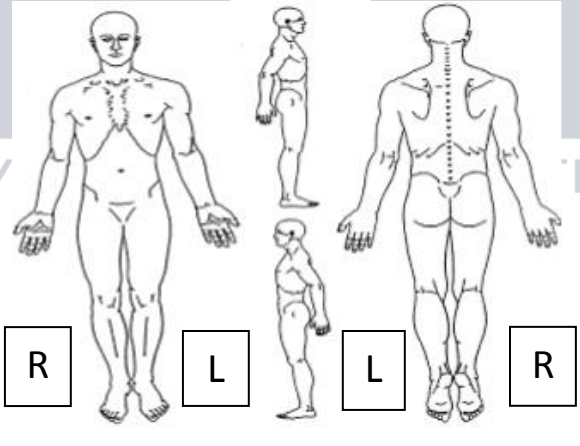
Have you had treatment for this issue in the past? _____

Is this a work related issue or a result of a motor vehicle accident? If yes, please specify.

_____

Instructions: *Mark these drawings according to where you feel your pain, by referring to the key below.*

Sharp /////	Burning XXXXX	Pins & Needles OOOOO	Aching +++++
Stabbing VVVVV	Numbness -----	Dull *****	Other vvvvv



Please circle your current pain level

no pain 0 1 2 3 4 5 6 7 8 9 10 **worst pain imaginable**

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Physical history

Musculoskeletal		**Nervous System**		**Cardio-Vascular-Resp.**	
Neck problems		Numbness		Chest pain	
Upper back problems		Loss of feeling		High/Low blood pressure	
Shoulder problems		Headaches		Difficulty breathing	
Low back problems		Dizziness		Persistent Cough	
Elbow problems		Fainting		Coughing phlegm/blood	
Knee problems		Confusion		Lung problems	
Ankle/foot problems		Depression		Diabetes	
Arthritis		Concussion		Asthma	
Other:		Anxiety		Varicose veins	
		Loss of balance		Hypoglycemia	
		Paralysis		Angina	
		Seizures		Murmur/palpitations	
		Forgetfulness		Hemophilia	
Gastrointestinal/Endocrine		**Genito-Urinary System**		**Ears/Nose/Eyes/Throat**	
Poor appetite		Painful urination		Vision problem	
Excessive hunger/thirst		Excessive urine		Ear ringing	
Heat/cold intolerance		Discoloured urine		Ear infections	
Nausea/vomiting		Urgency to urinate		Hearing loss	
Bloody/black stool		Recurring infections		Voice changes	
Weight loss/gain		Kidney stones		Gum/teeth/jaw problem	
Ulcer				Nasal discharge	
Thyroid problems				Nose bleeds	
Liver/Gall bladder problem				Sinus problems	
Female		**Male**		**Skin**	
PMS		Testicular pain		Moles	
Irregular cycle		Itching		Rashes	
Irregular bleeding/discharge		Sores		Acne	
Pregnancy		Irregular discharge/bleeding		Dryness	
Sores		Hernia		Itchiness	
Sexual concerns		Sexual concerns		Psoriasis	
Breast lumps/pain/tenderness/discharge		Chest lumps/pain/tenderness/discharge		Eczema	
Hernia					

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Family history

Illness	Circle		Family member
Alcoholism	Yes	No	
Allergies	Yes	No	
Anemia	Yes	No	
Arthritis	Yes	No	
Asthma	Yes	No	
Cancer	Yes	No	
Depression	Yes	No	
Drug abuse	Yes	No	
Diabetes	Yes	No	
Digestive problems	Yes	No	
Heart disease	Yes	No	
High blood pressure	Yes	No	
Kidney disease	Yes	No	
Mental illness	Yes	No	
Seizure	Yes	No	
Stroke	Yes	No	
Thyroid disorder	Yes	No	
Other	Yes	No	
Family history unknown	Yes	No	

Please indicate any serious conditions, illnesses, injuries and/or hospitalization

_____

_____

Please indicate any medications and/or supplements you are currently taking

_____

Lifestyle

Do you exercise? If yes, how many times per week? _____

Do you smoke? If yes, how many packs per day/week? _____

How would you rate your stress level? □ Mild □ Moderate □ Severe

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Consent to Chiropractic Treatment

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, electricalor light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areasof the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relievepain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improvefunction, 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 isa 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. Inthe most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain andnumbness 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.

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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.

Consent for collection of personal information and privacy policy

I understand that in order to provide me with chiropractic care, Active Health Institute will collect some personal information about me. We are committed to collecting, using and disclosing your personal information responsibly.

Disclosure:

1. The patient's doctor/health practitioner(s)
2. Other health practitioners of the Active Health Institute for the purpose of supporting patient health.

I understand how the Privacy Policy applies to me. I have been given a chance to ask questions I have regarding the Privacy Policy and they have been answered to my satisfaction.

Chiropractic Cost/Session

Initial Assessment (includes treatment)	$110.00
Subsequent treatment	$50.00 adult ($45.00 senior/student)
Extended treatment	$70.00
Chiro/acupuncture	$60.00

DO <u>NOT</u> 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.

Patient Name (Please Print): _____ **Date:** _____

Signature of patient (or legal guardian): _____

Signature of Chiropractor: _____ **Date:** _____