Dr. Ed's Gentle Chiropractic Clinic

DrEds.ca
(705) 742-4441

Confidential Health Record

Name: Birthdate (m/d/y):

Address: Gender: ☐ Male ☐ Female

City: Postal Code: Home Phone:

E-mail address: Cell Phone:

Workplace: Work Phone:

Check One: ☐ Single ☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: Medical Doctor: Phone:

Of Children: Have they ever had a spinal check-up? ☐Yes ☐ No

Are you interested in having their spines checked? ☐Yes ☐ No

MAIN HEALTH CONCERN: Referred to clinic by:

When in your lifetime did this problem first occur?

What activities are affected by this problem? ☐ Work ☐ Home ☐ Sports

Previous chiropractic care? ☐ No ☐ Yes - when?

Which position do you sleep in? ☐ Side ☐ Back ☐ Stomach

How committed are you to improving your health: (on a scale of 1-10, 10 being the highest) 1 2 3 4 5 6 7 8 9 10

Do you ever intentionally self adjust (crack) your own spine? ☐ No ☐ Yes

Have you been in an auto accident in last **2** years? ☐ No ☐ Yes

If yes, describe:

Have you had any other serious personal injuries or accident(s)? ☐ No ☐ Yes

If yes, describe:

Are you currently wearing custom foot orthotics? ☐ No ☐ Yes

Lifestyle stress level: ☐ High ☐ Moderate ☐ Very Little

Are you taking any (**prescription medications**?)

Drug	Condition	# Pills Per Day

Are you taking any (**over-the-counter medications**?)
Examples: (Tylenol/Tums/Antihistamines…)

Drug Name	Condition	# Pills Per Day

Please check the symptoms you have experienced in the **last 30 Days.**

- ☐ Neck pain/stiffness
- ☐ Headaches
- ☐ Migraines
- ☐ Ear infections/aches
- ☐ Sinus Problem (not cold /allergy related)
- ☐ Fevers (more than 1 per month)
- ☐ Sore throats (more than 1 per month)
- ☐ Visual disturbances (spots/sparks)
- ☐ Dizziness
- ☐ Chronically fatigued
- ☐ Sleeping problems (due to discomfort)
- ☐ Jaw (TMJ) pain
- ☐ Shoulder joint pain
- ☐ Elbow problems
- ☐ Wrist problems
- ☐ Arm/Hand (pain/numbness/tingling)
- ☐ Asthma
- ☐ Nausea/vomiting
- ☐ Gall bladder problems
- ☐ Heartburn
- ☐ Indigestion
- ☐ Constipation
- ☐ Diarrhea
- ☐ Urination excessive/painful
- ☐ Sleep interrupted by urination
- ☐ Bladder control/leaking
- ☐ Mid back pain/stiffness
- ☐ Lower back pain/stiffness
- ☐ Leg/Foot (pain, numbness, tingling)
- ☐ Leg weakness
- ☐ Calf muscle cramps
- ☐ Knee problems
- ☐ Ankle swelling
- ☐ Foot problems
- ☐ History of stroke

Females:

☐ are you pregnant? ☐ menstrual cramping? date of last period/cycle?______________
☐ menstrual irregularity? ☐ vaginal pain/infections?

Please read carefully,

I understand and agree that health insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Dr. Ed's Gentle Chiropractic Clinic will prepare any necessary reports and forms to assist me in collecting from my insurance. Any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures i.e., diagnostic x-rays, neurological scans, postural restoration exercises, personalized custom orthotics, by hand or instrument various modes of physical therapy by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic.

I will have an opportunity to discuss with the doctor of chiropractic/staff member, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to muscle strains, sprains, rib fractures, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have read the above consent, and if needed I will have an opportunity to ask questions about its content. By signing below I agree to the above-mentioned chiropractic procedures. I intend this consent form to cover the entire course of treatment for my present and all future conditions.

Signature____ Date Signed________________________

Witness____ Date Signed________________________