CHIROPRACTIC INTAKE FORM

Dr. Joan Shaben
Lendrum Health Centre
5846 – 111 Street, Edmonton, Alberta T6H 3G1

WELCOME TO LENDRUM HEALTH CENTRE. PLEASE ASSIST US IN PROVIDING THE BEST POSSIBLE CARE BY COMPLETING THE FOLLOWING INFORMATION. THIS INFORMATION IS VITAL IN ENSURING A MORE COMPLETE ASSESSMENT OF YOUR COMPLAINT.

Patient name: ____
(Last) (First) (Middle)

Date of Birth: ____________________ Age: ________ AB Health Care #: ____________________
(M/D/Y)

Address: ____
(Street/Apt.) (City/Town) (Postal Code)

Phone #: Home ________________ Bus/Other ________________ Cell ________________

Occupation: ______________ Employer: ______________ Email ________________

Emergency Contact: ____
(Name) (Phone #)

Referred to this office by: ____________________

CLAIM WILL BE MADE AGAINST:

1. **Motor Vehicle Accident:** Yes: _______ No: _______ (please initial)
   (If you have or are thinking of opening a claim as a result of a motor vehicle accident, you are required to complete the appropriate forms. This information will assist both you and the clinic in your claim.)

2. **Work Related Injury:** Yes: _______ No: _______ (please initial)
   (Important: Please note we are **NOT** an authorized WCB provider. Our chiropractors do **NOT** maintain contracts with WCB.)

Do you have an extended health care plan/coverage? Yes: _______ No: _______

Billing Procedures and Responsibilities
The patient is responsible for any/all fees.

Acknowledgement of Patient Fee Responsibility

I, ____________________, hereby accept full responsibility to pay any/all amounts, for chiropractic services. I also accept that this is non-negotiable and recognize all billings and claim submissions directed to my extended Health/ secondary insurance are my full responsibility.

Date: ____________________ Signature: ____________________

Personal Health History

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Please remember all information provided is confidential.

Name: ____________________ **Date of Birth:** ____________________

Why are you here today? (Current complaint or injury): ____________________

____

When did this condition begin? ____________________

Is this a first episode? ____________________
Yes/No (if no, describe previous episodes)

Please rate your overall health. ____________________
Poor/Fair/Good/Excellent

Health History
(Please note we are looking for information relative to why you're here today)

Lifestyles & Habits
To ensure a complete assessment/diagnosis please be as accurate as possible)

Do you smoke? Yes No Do you exercise? Yes No

Do you consume alcohol/narcotics? Yes No

Rate your diet: Poor Fair Medium Good

Have you ever been knocked unconscious? Yes No

Are you currently taking any medications? Prescribed: ____________________

Herbal/Vitamins/Other: ____________________

Falls and accidents (list): ____________________

Surgeries and operations: ____________________

Please list any family health conditions/problems: ____________________

____

____

Prior Health Care

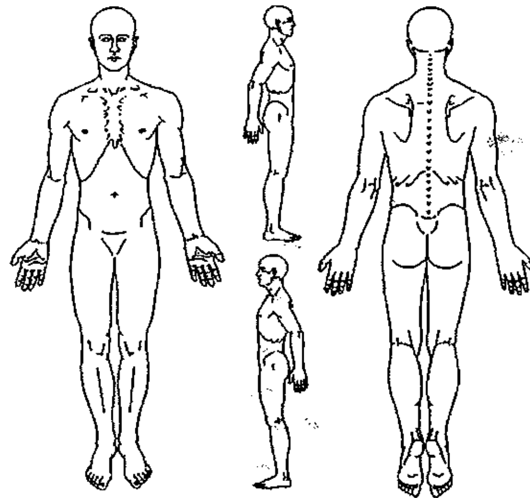
Prior Chiropractic care ____________________
Name Telephone Date of last appointment

Did you have x-rays taken? Yes No

Medical Doctor ____________________
Name Telephone Date of last appointment

Show area(s) of pain or unusual feeling:

Mark the area(s) on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.



Numbness:	• • • •
Pins and Needles	0 0 0 0
Burning	X X X X
Aching	* * * *
Stabbing	/ / / /

Please check any of the conditions below that you have had:

[ ]	Diabetes	[ ]	Cancer	[ ]	Heart Condition
[ ]	Stroke	[ ]	Obesity	[ ]	High Blood Pressure
[ ]	Asthma	[ ]	Allergies	[ ]	High Cholesterol
[ ]	Arthritis	[ ]	Osteoporosis	[ ]	Chronic Fatigue
[ ]	Fibromyalgia	[ ]	Psoriasis	[ ]	Multiple Sclerosis
[ ]	Eczema	[ ]	Irritable Bowel	[ ]	Chron's Disease
[ ]	Insomnia	[ ]	Headaches	[ ]	Depression

Females Only

[ ] Irregular Menses
[ ] Heavy Flow
[ ] Painful Menses
[ ] Breast Pain/Lumps
[ ] Vaginal Pain/Infections

Males Only

[ ] Enlarged Prostate
[ ] Low Sperm Count
[ ] Impotence

Please check any conditions you have had in the past six (6) months.

[ ]	Low Back Pain	[ ]	Leg Pain	[ ]	Neck pain
[ ]	Jaw Pain	[ ]	Arm Pain	[ ]	Upper Back Pain
[ ]	Joint Pain	[ ]	Numbness	[ ]	Dizziness
[ ]	Fainting	[ ]	Convulsions	[ ]	Cold Limbs
[ ]	Varicose Veins	[ ]	Ankle Swelling	[ ]	Visual Problems
[ ]	Dental Problems	[ ]	Ear/Throat	[ ]	Sinus Problems
[ ]	Poor Appetite	[ ]	Excessive Thirst	[ ]	Urinary Problem
[ ]	Constipation	[ ]	Diarrhea	[ ]	Low Energy

Signature: ______________________________ Date: ______________________________

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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, 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