King West Village Chiropractic Clinic

1002 King Street West. Toronto, ON M6K 3N2
416-597-1604 info@kingwestchiro.com

GENERAL PATIENT INFORMATION

Name: _____ Gender: M/F

Date of Birth: _____(MM/DD/YY) Occupation: _____

Address:

_____

City: _____ Province: _____ Postal Code: _____

Telephone:Home_____Work:_____Cell_____

Emergency Contact: _____ Tel: _____Relation:_____

E-mail Address: _____@_____

Would you like to receive a reminder for your subsequent appointments? Email / Phone

How did you hear about our clinic? Please circle	**Walk- in Yellow Pages Friend (who?)** _____ **Website Mailout Brochure Other** _____

Name of Medical Doctor:_____ Tel:_____

Address

_____

Date of last appointment: _____ Date of last physical: _____

Are you taking any medications? If so, what? _____

Permission to consult with the above Health Care Providers Yes/No

I (please print name), _____ give permission to the discussion of any of the information in this form amongst the Health Care Team at King West Village Chiropractic Clinic.

Signature: _____ Date: _____

(guardian if under 18)

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HEALTH HISTORY FORM

For your information:
An accurate health history is important to ensure that it is safe for you to receive chiropractic treatment. If your health status changes in the future, please let me know. All information gathered is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Today's Date: _____

Signature: _____ Date of Birth: _____

What is your primary complaint: _____

Please indicate conditions you are experiencing, or have experienced:

Respiratory
- ☐ Chronic cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Cardiovascular
- ☐ High or Low Blood pressure
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Easy Bruising
- ☐ Varicose Veins
- ☐ Blood Clots or Clotting Disorder

Infections
- ☐ Hepatitis
- ☐ TB
- ☐ HIV / AIDS
- ☐ Skin
- ☐ Other

Soft Tissue/Joint Discomfort and Its Nature
- ☐ Neck
- ☐ Low Back
- ☐ Mid back
- ☐ Upper back
- ☐ Shoulders
- ☐ Elbows
- ☐ Wrists / Hands
- ☐ Arms
- ☐ Hips
- ☐ Knees
- ☐ Ankles / Feet
- ☐ Legs
- ☐ Muscle Cramping
- ☐ Jaw
- ☐ Weakness or Paralysis (where_____)
- ☐ Other

Head /Neck
- ☐ Vision problems
- ☐ Ear problems (eg. fullness, ringing, loss)
- ☐ Head Trauma
- ☐ Headaches / Migraines
- ☐ Sinus Problems
- ☐ Past Whiplash Injury

Women
- ☐ Pregnant (due):
- ☐ Menstrual Backache
- ☐ Painful Periods
- ☐ Birth Control Method: _____

Other Conditions
- ☐ Loss of sensation
- ☐ Numbness / Tingling
- ☐ Dizziness
- ☐ Fainting
- ☐ Diabetes (onset):
- ☐ Allergies
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis (osteo or rheumatoid)
- ☐ Spinal Conditions
- ☐ Skin condition
- ☐ Chronic Fatigue
- ☐ Weight loss or gain
- ☐ Disc Herniation
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone Disease

What is your general health status?

Current Medications: _____

Condition it treats: _____

Recent Special Testing (blood work, x-rays, MRI etc_____

Injuries / Fractures: _____

Surgeries: _____

Do you smoke? No Yes (how much _____) Do you exercise? No Yes (how often _____ Type _____)

Present involvement in other health care: No Yes If yes, what other therapy are you receiving _____

Other Medical Conditions (i.e. digestive conditions, gynecological conditions, hemophilia, emotional or mental illness etc.)
_____

Of Special Note:(presence of internal pins, wires, artificial joints, special equipment):

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short-term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been know to occur following certain manual therapy procedures;

b) There have been reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustments is extremely remote;

c) There have been reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific study evidence has demonstrated such injuries are caused, or may be caused by spinal adjustments or other chiropractic treatment;

d)There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

I understand that I am responsible for the fee of each treatment at the completion of each treatment.

A 24 hours notice is required to cancel an appointment, otherwise you will be billed a missed appointment charge.

Today's Date: _____

_____ **Patient Signature (Legal Guardian)**

Name: _____ **(please print)**

_____ **Witness of Signature**

Name: _____ **(please print)**