HEALTH FIRST CHIROPRACTIC

Dr. Marty Thompson Chiropractic Corporation

Today's Date:_____

Name: L _____ F _____ Sex: Male _____Female _____
Address:_____
City: _____Postal Code:_____ Home Phone: # _____
Work: # _____Cell: #_____Email: _____
Height: _____ Weight:_____
Date of Birth: _____Age: _____
Occupation: _____Employer_____
Spouse's Name: _____
Name of Children and Ages: _____
Have you ever received Chiropractic care? Yes_____ No ____
If yes, who: _____ When:_____
Have you received spinal x-rays in the last 2 years? Yes _____No _____
Do you wear orthotics or special shoe inserts? Y/N (if yes, how old are they?) _____
Health Care #: _____
How did you find out about our office? _____
If you were referred to our office, who may we thank? _____
Is this related to a Motor Vehicle Accident in the **last 10 days**? Yes / No
If yes, Date:_____
Is this a work related injury (***WCB Claim***)? Yes_____ No _____
Is there a chance you could be **pregnant**? Yes _____ No _____

Existing Symptoms

If you have a specific primary complaint(s), please describe briefly: (Include how and when problem started)

_____

_____

MARK ALL THAT APPLY

Is the problem: Constant? _____ Intermittent? _____
Worse with movement? _____
Is the condition worse: In the AM? _____In the PM? ____
No Change?_____
The problem occurred: Gradually? _____ Suddenly? ____
Does it radiate?: Yes_____No_____ If yes, where?_____
Is the pain getting progressively worse? yes?____ No?___
Condition is worse with: Right rotation?___Left rotation? ___
Bending?: Forward?___ Backward? ____ Right?___ Left?___
The condition interferes with my? Sleep? _____Work?___
Daily Routine? ___ Family Life?____Exercise?____ Mood? ___

What activities aggravate your pain/condition?

_____

What (if anything) relieves your pain/condition?

_____

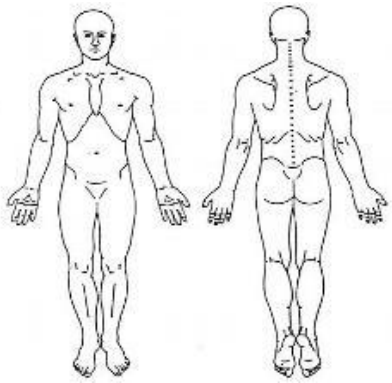
On a scale between 1 (no pain) and 10 (intense pain),
Place an X where you are currently at:

1----------3----------5----------8----------10

Show area(s) of pain or unusual feeling.

Mark the areas on this body where you feel the described sensations.

Use the appropriate symbols.



Numbness (XX), Pins/Needles (++), Aching (**), Burning (- -), Stabbing (//)

System Review

Please select anything you suffer from or have a history of suffering from below by marking "C" for current or "P" for previous and provide a brief description.

___Headaches		___Migraines	
___Neck Pain		___Ringing in Ears	
___Chronic Fatigue		___Upper Back Pain	
___Low Back Pain		___Shoulder Pain	
___Arm Pain		___Wrist Pain	
___Carpal Tunnel		___Constipation	
___Diarrhea		___Leg Pain	
___Foot Pain		___Depression	
___Sleeping Problems		___Dizziness	
___Allergies		___Cramping in Legs	
___Heartburn		___Vision Changes	
___Chest Pain		___Blood Pressure	
___Bladder Control		___Ear Infections	
___Sinus		___Sciatic Pain	
___Arthritis		___Swallowing Difficulty	
___Asthma		___Diabetes	
___Cancer		___Sexual Dysfunction	
___Osteoporosis		___Scoliosis	
___Degenerative Disc Disease		Other:_____ _____	

Is there family history of:
Heart Disease?_____ Stroke?_____ Cancer?_____ Diabetes?____ Other? _____

Please list any vitamins or medications you are currently on: _____

_____

_____

List any surgeries you have had and include when: _____

_____

_____

Lifestyle Events and Habits

The 3 main stressors that may compromise your well-being:

1. Physical Stress

Briefly describe any notable **injuries, head traumas, concussions, broken bones, slips**
(example: sports, horseback riding, tobogganing, falls down stairs, slips on ice, etc.) Remember to include how old you were at the time, as childhood injuries left uncorrected can lead to problems later in life>

_____

_____

List any **motor vehicle accident** injuries: include date if known and describe collision (rear-end, rollover, seatbelt, airbags?)

_____

_____

Do you spend **any** significant time:
Sitting?_____ Bending Forward?____Twisting?_____ Lifting?_____ Driving?_____ Computer?___
If yes to sitting/driving/computer, how many hours per day do you spend at these activities? _____
Do you exercise on a regular basis? Yes___ No___
Do you sleep on your: Back?___ Side?___ Stomach?___

Rate your posture out of 10 (1—poor 10—excellent):
1----------3----------5----------8----------10

Rate the amount of physical stress that your body goes through on a daily basis:
(1—no physical stress 5—moderate physical stress 10—heavy stress load):
1----------3----------5----------8----------10

2. Chemical Stress

Do you smoke, if so, how much and how long? _____
Drink Alcohol: Daily?____ Week-ends?____ Socially?____
My caffeine intake is: Low?___ Moderate?___ High?___
I eat processed foods: Rarely?___ Occasionally?___ Often?___
I use over the counter drugs (Aspirin, etc): Rarely?___ Occasionally?___ Often?___

3. Emotional Stress

My stresses include: Work?___ Home?___ School?___ Finances?___ Family?___
Relationships?___ Health Problems?___ Other?_____

Rate your stress level (1—rarely 10—always stressed)
1----------3----------5----------8----------10

OFFICE USE ONLY

BWD L _____ R _____
FTN: + -
BALANCE TEST: + - (R / L)
MITTLEMEYERS: + - (FORWARD/ R / L)

ROM: C-SPINE:

Rot R (N ↓ (with pain/without pain) _____
Rot (N ↓ (with pain/without pain) _____
Lat R (N ↓ (with pain/without pain) _____
Lat L (N ↓ (with pain/without pain) _____
Flex (N ↓ (with pain/without pain) _____
Ext (N ↓ (with pain/without pain) _____

T-L SPINE:

Rot R (N ↓ (with pain/without pain) _____
Rot L (N ↓ (with pain/without pain) _____
Lat R (N ↓ (with pain/without pain) _____
Lat L (N ↓ (with pain/without pain) _____
Flex (N ↓ (with pain/without pain) _____
Ext (N ↓ (with pain/without pain) _____

Dr. use only
Carotid Artery auscultation Bruits Yes/No

N=Normal/↓ = decreased

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 known to occur following certain manual therapy procedures;

B) There are 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 the 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 adjustment is extremely remote;

C) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific 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.

Dated this _____ day of _____, 20____.

_____ _____

Patient Signature (Legal Guardian) Witness of Signature

_____ _____

Name (please print) Name (please print)

EMAIL CONSENT FORM

Health First Chiropractic is constantly trying to improve our service to our valued patients. In relation to new laws in Canada regarding electronic messaging we are asking your permission to send you electronic messages from time to time, primarily for appointment reminders, but also periodically monthly educational information and or promotional materials. If at any time you wish to cancel this service you can reply "UNSUBSCRIBE" and we will delete your email address from our system.

I _____ _____ give consent to Health first chiropractic to communicate with me via email or electronic messaging. I understand that I can unsubscribe from this at anytime by replying "UNSUBSCRIBE".

EMAIL _____

Printed Name _____

Signature _____

Date _____

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