# Chiropractic

HealthTweak

Patient # _____

## PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Gender: _____ Employer: _____ Occupation: _____

E-mail: _____ May we contact you via e-mail? Y / N

Spouse/Partner: Y / N Children: Y / N #: _____

Medical Doctor: _____ Location: _____ Last Visit: _____

***How did you hear about us?*** ☐*Existing patient* _____

☐*Online* ☐ *Doctor* ☐*Other:*_____

## HEALTHCARE HISTORY

Have you ever seen? ☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist ☐ Naturopath

Date of last visit: _____ _____ _____ _____

Have you ever had? ☐ X- Ray ☐ MRI ☐ CT ☐ Ultrasound

## WHAT IS THE NATURE OF YOUR VISIT?

☐ Wellness (help me to always be at the highest level of health)

☐ Restorative (help me to restore my health)

☐ Injury (help me to get out of pain)

Please explain your health challenges in order of importance to you:

1) _____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

What does this challenge stop you from doing? _____

Have you seen anyone about this challenge? _____

Prior treatments and results? _____

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2) _____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

What does this challenge stop you from doing? _____

Have you seen anyone about this challenge? _____

Prior treatments and results? _____

3) _____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

What does this challenge stop you from doing? _____

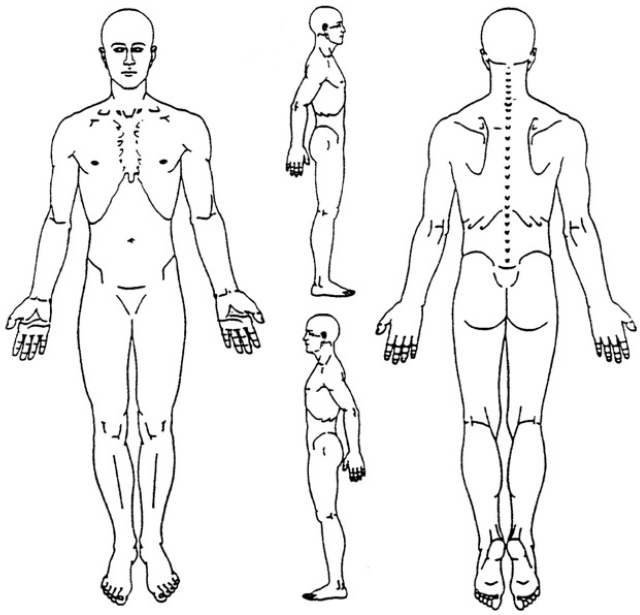
Have you seen anyone about this challenge? _____

Prior treatments and results? _____

## Please Draw Your Area of Concern

Use letters to indicate type
and location of discomfort:

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles



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## HEALTH INFORMATION

Past injuries: (birth complication, teen trauma, emotional trauma, severe stress, injuries, work injuries, car accidents, surgeries, broken bones, etc)

Emotional trauma: _____

Chemical trauma: _____

Physical trauma: _____

Surgeries/Hospitalizations: _____

Health conditions treated for in the past year:

_____

_____

## Medication and Supplements

Please list any *medications* you are taking: *Purpose and dose*:

_____ _____

_____ _____

_____ _____

_____ _____

Please list any *supplements* you are taking: *Purpose and dose*:

_____ _____

_____ _____

_____ _____

_____ _____

## Gynecology and Pregnancy

Age of first period: _____ Any chance you may be pregnant? Y ☐ N ☐ If so, # of weeks_____

First day of your last period? _____ How long does your period last? _____

How long is your cycle (first day of menses to last day before they start again)? _____

Are your menses? Irregular ☐ Painful ☐ Heavy ☐

Do you experience hot flashes? Y ☐ N ☐

Date of last PAP : _____ Normal cells ☐ Abnormal cells ☐

Are you using any method of birth control? If yes, what type?_____

How long have you been using this method? _____

Do you experience any changes with your body or emotions prior to your menses/period or at any specific point in your cycle? _____

Have you ever been pregnant? If yes;

# of live pregnancies _____ # of miscarriage _____ # of abortions _____

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# HEALTH CONDITIONS

Please check the following that apply to you:

- ☐ Seizures
- ☐ Allergies _____
- ☐ HIV
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Thyroid Disease
- ☐ Cystic Fibrosis
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Other Major Illness
- ☐ Rheumatic Fever
- ☐ Cancer
- ☐ Venereal Disease

**General**

- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Nausea/vomiting
- ☐ Fevers
- ☐ Lumps
- ☐ Masses
- ☐ Dizziness
- ☐ Double vision
- ☐ Problems swallowing
- ☐ Problems talking
- ☐ Loss of consciousness
- ☐ Loss of balance

**Gastrointestinal**

- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating/Gas
- ☐ Laxative use
- ☐ Bad Breath
- ☐ Nausea/vomiting
- ☐ Abdominal cramps/pain
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Blood in stool

**Respiratory**

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Pain w/breathing
- ☐ Mucous Production

**Learning Disability**

- ☐ ADHD
- ☐ Dyslexia
- ☐ Memory loss
- ☐ Autism spectrum

**Neuropsychological**

- ☐ Depression
- ☐ Disinterest
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Eating Disorder
- ☐ Concussion
- ☐ Fainting
- ☐ Dizziness
- ☐ Neuropathy
- ☐ Numbness
- ☐ Neurological condition (MS, ALS)

**Ear/Nose/Throat/Eyes**

- ☐ Vision loss/blurring/pain
- ☐ Hearing loss/ringing
- ☐ Sinus infections/problems
- ☐ Ear infections
- ☐ Nose Bleeds
- ☐ Problems with teeth
- ☐ Night Blindness
- ☐ Sores on lips, tongue or m
- ☐ Facial Pain
- ☐ Recurrent sore throat

**Genitourinary**

- ☐ Increased frequency
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Discharge
- ☐ Kidney Stones
- ☐ Bladder/Yeast Infections
- ☐ Genital Sores
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Urgency to void
- ☐ Wake at night to void

**Cardiovascular**

- ☐ Chest pain
- ☐ Stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Irregular Heartbeat
- ☐ Swelling hands/feet
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Impotence

**Adrenal**

- ☐ Mental fog
- ☐ Poor focus
- ☐ Quick to react
- ☐ Low energy
- ☐ Fatigue
- ☐ Headache
- ☐ Chest tightness
- ☐ Restless legs
- ☐ Susceptible to stress

***Doctor Section***

- ☐ Vascular
- ☐ Metabolic
- ☐ Aneurism
- ☐ Neoplasm
- ☐ Infection
- ☐ Congenital
- ☐ Trauma

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## LIFESTYLE

What is the biggest stressor in your life? ☐ Family ☐ Work ☐ Social ☐ Financial ☐ Health ☐ Time

What do you love to do in your spare time (hobbies)? _____

How often do you exercise? ☐ Daily ☐ 3-5 days/week ☐ 1-2 days/week ☐ Infrequently

Smoke? Y / N # Packs/week _____ Drink alcohol? Y / N # Drinks/week _____

Recreational Drug use: _____

Hours of sleep? _____ Feel rested? _____

Where is your current level of health? (circle) Very low Poor OK Good Excellent

If you had excellent health, what would you love to be able to do? _____

## FAMILY PROFILE

At Health*Tweak* we are here to help you and family live healthy and happy. Please mention below any health conditions or concerns they may have:

Children: _____

Spouse/Partner: _____

Other family members: _____

## PERSONAL HEALTH INFORMATION CONSENT FORM

I understand that Health*Tweak* is my health information custodian. I consent to the collection, use and disclosure of my personal health information for treatment and other health care reasons. Health*Tweak* is a multidisciplinary clinic, and therefore treatment notes may be shared between practitioners to best treat the patient.

I understand that to provide me with Massage Therapy, Chiropractic, Physiotherapy, Naturopathic Medicine or any other health care services, Health*Tweak* will collect personal information about me (e.g. birth date, home contact information, health history, etc.)

I understand that Health*Tweak* will only collect, use, or disclose my personal health information with my express or implied consent; unless a collection, use, or disclosure without consent is permitted or required by law.

◯ I give permission to HealthTweak to contact your primary healthcare provider such as my medical doctor, nurse practitioner ect.

Name: _____ Name of Witness: _____

Signature: _____ Date: _____

**Thank you for completing this form.**

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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.

**HealthTweak is a multidisciplinary clinic; therefore other practitioners may have access to your file. If this poses any concern please let us know.**

**Alternatives**

Alternatives to chiropractic treatment may include consulting with 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)*

_____ _____
Signature of Patient (or legal guardian) Date

_____ _____
Signature of Chiropractor Date