Adult Health Record

It is a pleasure to welcome you to our family of healthy and happy chiropractic practice members. Please let us know if there is any way we can make you and your family feel more comfortable. We look forward to working with you to build better health for you and your family.

Name:		Email address:	
Address:		City:	Postal Code:
Contact number: home work cell ( )	Other: home work cell ( )	Date of Birth (dd/mm/yyyy):	Sex: ☐M ☐F
Occupation:		Employer:	
Marital status: ☐single ☐married ☐widowed ☐separated/divorced		Spouse's name:	Spouse's occupation:
Do you have children? ☐ Yes ☐ No	What are their names and ages?		
Have you ever received chiropractic care before? ☐ Yes ☐ No If yes, when was your last visit?		Have you had spinal x-rays taken in the last 12 months? ☐ Yes ☐ No Body part(s):	
Whom shall we thank for referring you into our office?			

Your birth process

Delivery ☐ long and difficult (# of hrs -) ☐ forceps ☐ caesarean ☐ vacuum extraction ☐ breech

Was your mother given ☐ drugs ☐ epidural ☐ induced – gel or drip

Other complications _____

Growth and development

Were you taught how to care for your spine? ☐ Yes ☐ No

Were you breast fed? ☐ Yes ☐ No

How many of the following did you have? ☐ childhood falls_____ ☐ accidents_____

☐ sports injuries_____ ☐ auto collisions_____ ☐ other _____

Health history

Have you ever been hospitalized? ☐ Yes ☐ No Why?_____ When? _____

Have you ever had surgery? ☐ Yes ☐ No Why? _____ When? _____

Have you ever broken a bone? ☐ Yes ☐ No Where? _____ When? _____

Current health habits

Do you smoke? ☐ Yes ☐ No packs/day _____

Do you drink alcohol? ☐ Yes ☐ No drinks/week ____

Do you visit the dentist regularly? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No hrs/wk _____

Do you belong to a gym or sports club? ☐ Yes ☐ No

Sleeping posture ☐ stomach ☐ back ☐ side # of pillows: ____

How long do you sleep per night? _____ hrs

Rate your stress level on an average day (1 – low, 10 – extremely high): _____

SYMPTOMS

Years of uncorrected injury or damage show up as acute or chronic symptoms or health problems.

Main purpose for this visit: _____

When did this condition begin? _____

What else have you tried for this condition? _____

At its worst, this problem interferes with: ☐ my ability to work ☐ hobbies/sports ☐family/social time

If this problem is not corrected, do you think it will get worse in the next 5-10 years? ☐ Yes ☐ No

On a scale of 1 to 10 (10 being the highest), what is your commitment to improving your overall health?
1 2 3 4 5 6 7 8 9 10

Are you any taking any medications or supplements? ☐ Yes ☐ No

Names: _____

Please check any body signals that are or have caused you problems in the <u>past 12-18 months</u> *even if you think they are unrelated to your current concerns….*

Musculoskeletal System
- ☐ neck pain/stiffness
- ☐ low back pain
- ☐ pain between shoulders
- ☐ pain or weakness in: shoulders arms hands fingers buttock hips legs feet toes
- ☐ cold hands or feet
- ☐ arthritis/swollen joints
- ☐ spinal curvature
- ☐ walking problems
- ☐ jaw problems

Nerve System
- ☐ headaches/migraines
- ☐ numbness, tingling or weakness
- ☐ dizziness/lightheaded
- ☐ fainting
- ☐ loss of sleep
- ☐ convulsions/seizures
- ☐ nervousness/anxiety/depression
- ☐ poor concentration/memory

Immune System
- ☐ fever
- ☐ frequent colds/flu
- ☐ bronchitis/pneumonia
- ☐ sinus problems
- ☐ asthma
- ☐ allergies
- ☐ ear infection/tonsillitis

Circulatory System
- ☐ chest pain
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ stroke
- ☐ shortness of breath
- ☐ heart problems
- ☐ fatigue/chronic tiredness

Digestive System
- ☐ nausea/vomiting
- ☐ excessive gas/bloating
- ☐ indigestion/heartburn
- ☐ black/bloody stools
- ☐ appetite changes
- ☐ excessive thirst
- ☐ blood sugar/diabetes
- ☐ constipation
- ☐ diarrhea/irritable bowel
- ☐ colitis
- ☐ liver/gall bladder trouble
- ☐ hemorrhoids
- ☐ weight changes gain/loss

Eyes/Ears/Nose/Throat
- ☐ visual disturbances
- ☐ deafness/hearing problems
- ☐ ears ringing (tinnitus)
- ☐ earaches
- ☐ sore throats
- ☐ loss of smell/taste
- ☐ difficulty swallowing
- ☐ thyroid problems

Kidney/Bladder
- ☐ kidney infections/stones
- ☐ problems with urination
- ☐ increase frequency/ lose control
- ☐ kidney/bladder/prostate
- ☐ sexual dysfunction
- ☐ infertility

Women only:
- ☐ menstrual problems
- ☐ excessive cramps/pain
- ☐ irregular cycle
- ☐ menopause
- ☐ breast pain/lumps

last period: _____

pregnant: ☐ Yes ☐ No ☐ Not sure

Terms of Acceptance

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking about, and working towards the same goal. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

TO LOCATE, ANALYZE AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment or improper motion producing nerve interference), in and of itself, is a detriment to life and health. Correction of the SUBLUXATION through a specific chiropractic adjustment allows the body to function at its optimal level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain and promote health.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including diagnostic x-rays (if necessary) on me by the doctor and/or anyone working in this clinic authorized by the doctor.

I will have an opportunity to discuss with the doctor and/or staff, the nature and purpose of chiropractic adjustments and other procedures. I understand that the results expected are not guaranteed, as every person is unique.

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

I have read the above consent. I will have an opportunity to ask questions about this consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of care for my present condition and for any future condition(s) for which I seek care in this office.

TO BE COMPLETED BY PATIENT

_____ _____

Print Name Signature of Patient (or parent/guardian)

_____ _____

Witness Date Signed

Ancaster Family Chiropractic
397 Wilson Street East
Ancaster, Ontario

X-RAY RELEASE FORM

This is to certify that Ancaster Family Chiropractic has permission to take x-rays if necessary.

Print Name: _____

Signature:_____ Date:_____

Witness: _____ Date: _____

Women Only

This is to certify, to the best of my knowledge, that I am **NOT** pregnant.

Signature:_____ Date:_____