



HEALTH FOR LIFE CHIROPRACTIC

AT CLOVERDALE MALL

UNIT #143-250 THE EAST MALL ETOBICOKE, ON, M9B 3Y8

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Dr. Chrystopher Sly B.Sc, D.C.

Adult Health Questionnaire

Name _____ M___/F___ Date _____
Address _____ City _____ Postal Code _____
H. Phone _____ W. Phone _____ Cell Phone _____
E-mail _____ Date of Birth (dd/mm/yy) _____
Can we contact you by e-mail _____ text message _____
Occupation _____ Number of children and Ages _____
Have you seen a Chiropractor before? When? _____
Family Practitioner Name and Address _____
Referred By _____

About Your Health

You were born to be healthy! Unfortunately your health, your Innate Intelligence, can be interfered with. As Deepak Chopra M.D. has discovered, "All disease results from the disruption of the flow of intelligence." Chiropractic removes this interference when it happens in the spine (vertebral subluxations/VSC) so you can express your natural health potential throughout life!

1a. Is this a wellness check-up or do you have a specific health concern?

b. What is your major complaint? (Please describe)

c. Is the condition interfering with work? _____ Sleep? _____ Hobbies? _____

d. Have you consulted anyone else for this condition?

e. Have you tried anything to get rid of this problem?

Name: _____

f. Other symptoms you have experienced in the last 6 months: (please circle)

Headaches	Pins & Needles Leg	Loss of smell
Neck	Pins & Needles Arm	Loss of taste
Sleeping Problems	Numbness in toes	Diarrhea
Back pain	Shortness of breath	Feet cold
Nervousness	Fatigue	Hands cold
Tension	Depression	Stomach upset
Irritability	Cold Sweats	Dizziness
Chest pain	Constipation	Ears ring
Loss of memory	Fever	Allergies
Loss of balance	Fainting	

2. **Birth Process (Your own)** (Please fill out to the best of your knowledge)

Was your delivery long? _____
Was your delivery difficult? _____
Forceps? _____
Caesarean? _____
Breach/ Cephalic? _____
Home birth? _____
Hospital birth? _____
Mother given drugs during delivery? _____
Was labor induced? _____

3. **Growth & Development** (Please fill out to the best of your knowledge)

Were you breast-fed? _____
Childhood sickness? _____
Accidents? _____
Surgery? _____
Drugs? _____
Any Falls? _____
Did you have other traumas? What? When? _____

Name: _____

4. **Current Health Habits**

Did / do you smoke? _____

Did/ do you drink alcohol? _____

Diet (do you eat healthy foods)? _____

Have you been involved in any car accidents? When?

Have you had any surgery or organs removed or replaced?

Drugs? (prescriptive or non-prescriptive)

Teeth problems? _____

Eye problems? _____

Hearing problems? _____

Physical exercise? _____

Sleeping habits (position)? _____

Did/ do you have occupational stress? _____

Physical stress? _____

Mental stress? _____

Hobbies / Sports injuries? _____

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care**, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. **Reconstructive Care** begins after this and corrects the years of damage that have occurred; this will be explained at your report of findings. Then you will be able to begin a course of care that fits your health goals.

Examination Fees

	<u>Cost</u>
Consultation	-----Complimentary-----
Examination	\$70.00
X-rays (if applicable)	\$90.00

Consent to Examination and X-rays (if applicable)

Patient Signature (Legal Guardian) : _____

Date: _____

Date of last menstrual period? _____

Are you currently pregnant? Y/N _____

Name: _____

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 issues. 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.

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

Name: _____

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)

Signature of patient (or legal guardian)

Date: _____ 20__

Signature of Chiropractor

Date: _____ 20__