Introduction and History

Full Name

Date

City

Province

Postal Code

Date of Birth (mm/dd/yyyy)

Gender
O Male O Female

Marital Status
O S O M O CL O D O W

Number of Children

Telephone Number (Res)

Telephone Number (Bus)

Telephone Number (Cell)

Occupation

Email

Who referred you to our clinic

What is your reason for seeking chiropractic care at this time?

Your Health Profile

Have you previously seen a Chiropractor?
O Yes O No

When?

Dr. Name:

WHY IS THIS IMPORTANT:

As a wellness based chiropractic office, we focus on your ability to be healthy. Our first goal is to address the issues that brought you here and secondly, to offer you the opportunity of continually improving your health and wellness. Stresses can accumulate over many years and affect your health. Answering the following questions will give us a better profile of the specific stresses you have faced in your lifetime.

Do/did you smoke?
O Yes O No

Do/did you drink alcohol?
O Yes O No

Did you have any surgeries?
O Yes O No

Involved in any accidents (car/work)
O Yes O No

Any prolonged use of medications (eg. Inhalers/Antibiotics/Cholesterol)?
O Yes O No

Have you fractured any bones?
O Yes O No

On a scale of (mild) 1 to 10 (severe), describe your level of stress

Personal

O 1 O 6
O 2 O 7
O 3 O 8
O 4 O 9
O 5 O 10

Occupational

O 1 O 6
O 2 O 7
O 3 O 8
O 4 O 9
O 5 O 10

Do you exercise?

How often (days/week)

What type

Do you take medications regularly for:

O Heart
O Depression
O Diabetes
O Pain
O Arthritis
O Sleep
O Cholesterol
O Others: ______________________________

Name of Medication (s)?

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR CLINIC

If you are experiencing pain, is it:

O Sharp
O Dull
O Constant
O Intermittent
O Radiating
O Other: ______________________________

Did it occur:

O Suddenly
O Gradually

How would you rate your pain on a scale of (mild) 1 to 10 (severe)?

O 1	O 6
O 2	O 7
O 3	O 8
O 4	O 9
O 5	O 10

Since the problem started is it:

O About the same
O Getting better
O Getting worse

What makes it worse?

Does it interfere with:

O Work
O Sleep
O Walking
O Sitting
O Hobbies
O Leisure
Others: ____________________

Other Doctors/Therapists seen for this problem (please list):

Chiropractor:

Medical Doctor:

Other:

Please check the conditions for which you have been treated:

O Heart Disease
OIndigestion
O Bronchitis
O Depression
O Cancer
O Dizziness
O Stroke
O Ulcers
O Concussion
O Asthma
O Blood Pressure

PHIPA AGREEMENT

For individuals enrolled in the Adult Health Profile form who receive Protected Health Information from their Doctors Informed Consent.

You acknowledge to Pike Chiropractic Healing Centre that you receive chiropractic care which enables your Doctor to transmit protected health information (“PHI”) and other data to your authorized email account on your computer device through the Pike Chiropractic Healing Centre website.

By signing below, you authorize your Doctor to utilize the Adult Health Profile form to transmit your PHI and Data to your authorized email account and agree to maintain such authorized email account on a secure basis, with a confidential User Name and Password. You further acknowledge and agree that any disclosure of your PHI and Data after transmission to you (“Transmitted PHI and Data”) through the website by the Doctor will be deemed to be under your custody and control thereafter, and the Doctor shall not have any responsibility by PHIPA for any further disclosure of such Transmitted PHI and Data to any party, whether authorized or unauthorized, which may occur.

Pike Chiropractic Healing Centre Informed Consent

Please read carefully:

Our clinic is dedicated to helping you in recovering your health naturally. Please review the following paragraphs and sign in the area provided.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment to the Doctor. All fees are due at time of service.

In order to make a determination on the suitability of my case for chiropractic care, and to provide said care, I hereby request and consent to a thorough chiropractic assessment by the Doctor of Chiropractic indicated below and/or anyone working in this clinic authorised by the said doctor, which may include an x-ray examination if clinically indicated, chiropractic adjustments and other chiropractic procedures such as but not limited to orthotics and other orthopaedic supports. I have had the opportunity to discuss with the Doctor of Chiropractic and/or with other clinic staff, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed and I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to care, including but not limited to muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complication. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

I have read the above Consent. I have also had an opportunity to ask questions about it’s content and by signing below I agree to the above mentioned chiropractic procedures. I intend this Consent Form to cover the entire course of care and I understand that I may withdraw my consent at any time.

____

Signature over Full Name