INFORMED CONSENT TO EXAMINATION & X-RAY:

I hereby request and consent to the performance of a Chiropractic, Orthopaedic and Neurological examination and diagnostic x-rays (if required) which will determine if Chiropractic can help me. I understand that in some cases, the examination may aggravate my present condition.

Name: ______________________________ Signature: ____________________________ Date: ________________
(please print)

FOR WOMEN ONLY:

Dat of last period? ______________________________ Are you pregnant? ☐ YES ☐ NO ☐ MAYBE

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, custom foot orthotics or subsequent diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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

I have read the above consent for chiropractic adjustments and care.

I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE TO THE ABOVE NAMED PROCEDURES.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

______________________________ ______________________________
PATIENT'S NAME (please print) SIGNATURE OF PATIENT (or parent/guardian)

______________________________ ______________________________
DATE SIGNED WITNESS TO SIGNATURE ABOVE

Dr. Frazer D. Smith Dr. Mark A. Czubak
Smiths Falls Family Chiropractic
22 William St., W., Smiths Falls, ON K7A 1N1 (613) 283-4100

CONFIDENTIAL PATIENT INFORMATION

NAME: ______________________________ TODAY'S DATE: ______________

PHONE: RES ______________ BUS ______________ CELL ______________

EMAIL ______________________________

ADDRESS ______________ CITY ______________ POSTALCODE ______________

DATE OF BIRTH ______________ ☐ SINGLE ☐ MARRIED ☐ COMMON LAW ☐ SEP ☐ DIV ☐ WIDOW/ER

NO OF CHILDREN ______________ FAMILY PHYSICIAN ______________

OCCUPATION ______________ NO. YRS. _____ EMPLOYER ______________

What have you heard about chiropractic care? ______________

Are you interested in a preventive approach? ______________

Who may we thank for recommending our services to you? ______________

YOUR HEALTH PROFILE

Why this form is important: We are a wellness and family oriented chiropractic office, serving Smiths Falls since 1997. We strive to help you with the health reason you have consulted us today. We offer you the opportunity towards improving your overall ability to be optimally healthy in the future as well. On a daily basis, we experience layers of physical, chemical and emotional stress that accumulate and result in serious loss of our health potential, and often illness. Usually these effects are gradual and are not painful, but they do reduce our ability to function at our best, day to day. Answering the following questions will give us a profile of the specific concerns and stresses you have faced in your lifetime. This will allow us to help you with your immediate condition, and if you wish, help you achieve a healthy strategy for the future.

CHILDHOOD AND ADOLESCENCE

Research shows that many health challenges we experience have their roots during the developing years, some starting at birth. Please answer the following questions to the best of your ability.

CHILDHOOD

Did you have childhood Illnesses? ☐ YES ☐ NO

Did you have any serious falls as a child? ☐ YES ☐ NO

Did you play youth sports? ☐ YES ☐ NO

Did you take/use any drugs? ☐ YES ☐ NO

Have you fallen/jumped from a height over 3 ft? ☐ YES ☐ NO

Were you involved in any car accidents? ☐ YES ☐ NO

Was there prolonged use of antibiotics or inhalers? ☐ YES ☐ NO

Did you suffer physical or emotional trauma? ☐ YES ☐ NO

Were teeth extracted or dental orthodontics used? ☐ YES ☐ NO

Were you vaccinated? ☐ YES ☐ NO

Were you under regular chiropractic care? ☐ YES ☐ NO

ADULT YEARS (AGE 18 TO PRESENT)

Do/did you smoke? ☐ YES ☐ NO per day______

Do/did you drink alcohol? ☐ YES ☐ NO per day______

Do you skip meals? ☐ YES ☐ NO per day______

Do you drink coffee? ☐ YES ☐ NO per day______

Do you spend on a computer/ laptop/cellphone daily? Hours per day______

Have you been in any accidents? ☐ YES ☐ NO

Have you had any surgery? ☐ YES ☐ NO

Do/did you play any adult sports? ☐ YES ☐ NO

Do/did you participate in extreme sports? ☐ YES ☐ NO

Do you take time for family outings/fun and holidays? ☐ YES ☐ NO

On a scale of 1-10 (10 being very high), describe your stress level

Occupation ________ Personal ________

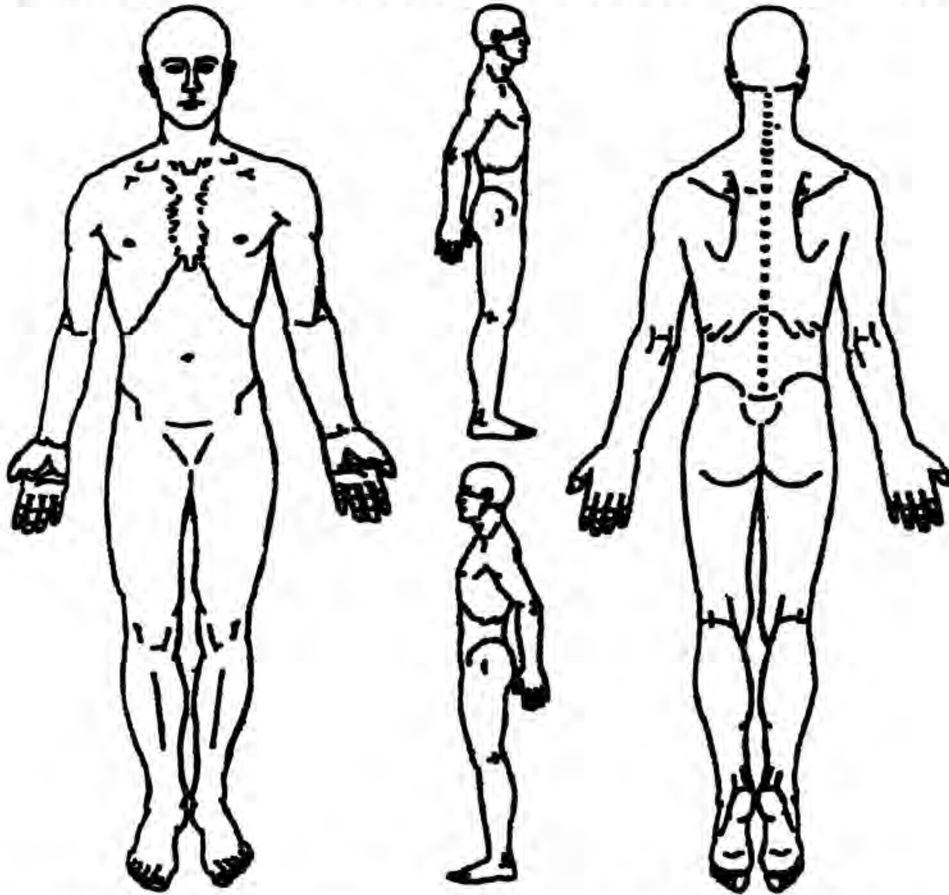
I understand that my personal information will be kept confidential according to the Regulated Health Practitioners Act and Privacy Legislation.

______________________________ SIGNATURE

______________ DATE

If you have no complaints or symptoms, and are here for a wellness assessment, please check ☐ .....and proceed to "Health Profile"

Please describe the locations of your chief complaint using the key below. Chiropractic assesses the whole body, so please indicate all areas of concern, even if you think they are unrelated to your chief concern. (eg. Jaw discomfort, digestive discomfort, ear/balance trouble, wrist discomfort)



Place letters of key at your areas of concern.

KEY
- **A – ache**
- **B – burning**
- **N – numbness**
- **P – pins/needles**
- **S – stabbing**
- **O – other**

Using the scale below, please rate your present level of ability *(10 - Full ability; 0 - No ability)*

1. Family	0	1	2	3	4	5	6	7	8	9	10
2. Recreation	0	1	2	3	4	5	6	7	8	9	10
3. Social Activity	0	1	2	3	4	5	6	7	8	9	10
4. Occupational	0	1	2	3	4	5	6	7	8	9	10
5. Self Care	0	1	2	3	4	5	6	7	8	9	10
6. Life Support (sleep, eating, breathing)	0	1	2	3	4	5	6	7	8	9	10

NOTES:

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______

When did this condition(s) begin? ______________________

Has it occurred before? ______________________

How frequent is the complaint? ☐ CONSTANT ☐ DAILY ☐ INTERMITS ☐ NIGHT ONLY

Since it began, is it ☐ ABOUT THE SAME ☐ GETTING BETTER ☐ GETTING WORSE

What makes it worse? ______________________

How long does it last? ☐ ALL DAY ☐ A FEW HOURS ☐ MINUTES

What relieves the problem for you? (eg. rest, ice, heat, stretching, medication) ______________________

Is it ☐ MILD ☐ MODERATE ☐ SEVERE

HEALTH PROFILE

Please check all categories you have ever experienced, even if you think they are unrelated to your concern

☐ Headaches	☐ Numbness in fingers	☐ Trouble swallowing	☐ Pins and needles in arms
☐ Fatigue	☐ Shortness of breath	☐ Dizziness	☐ Sleep problems
☐ Stiff neck	☐ Loss of Balance	☐ Jaw grinding	☐ Neck pain
☐ Slouched posture	☐ Buzzing/sounds in ears	☐ Sensitive eyes	☐ Cold Sweats
☐ Back pain	☐ Bloating	☐ Mood swings	☐ Menstrual pain
☐ Heartburn	☐ Depression	☐ Menstrual irregularity	☐ Ulcers
☐ Loss of smell	☐ Hot flashes	☐ Gastric Reflux	☐ Loss of taste
☐ Fevers	☐ Tension in chest	☐ Cold hands	☐ Feeling faint on rising quickly
☐ Cold feet	☐ Diarrhea	☐ Irritability	☐ Nervousness/Anxiety
☐ Constipation	☐ Problems urinating	☐ Separation/divorce	☐ Pins and needles in legs
☐ Bathroom visits to urinate at night	☐ Change in job status/work stress	☐ Numbness in toes	☐ Upset stomach
☐ Recent death of a loved one			

Please note any major illness you have had:

☐ Alcoholism	☐ Diabetes	☐ Anemia	☐ Ulcers	☐ Eczema
☐ Arthritis	☐ Arteriosclerosis	☐ Epilepsy	☐ Pneumonia	☐ Cancer
☐ Stroke	☐ Heart Disease	☐ Other: ______		

Have you ever: ☐ Been Unconscious? ☐ Used a cane? ☐ Fractured a bone? ☐ Been Hospitalized

Please list the specifics of any major accidents or surgeries ______________________

Please list any medical/dental/visual tests that you have received in the last 2 years

☐ Spinal Examination	☐ Physical Examination	☐ Blood Test	☐ Urine Test
☐ X-ray	☐ CT	☐ Ultrasound	☐ Other: ______

Are you taking medication for any of the following: (Tick all that apply)

☐ Nerve/Stress	☐ Pain	☐ Muscle Relaxants	☐ Pep/Energy	☐ Blood Pressure
☐ Heart	☐ Cholesterol	☐ Blood Thinners	☐ Other: ______	

Please list the natural supplements you take ______________________

YOUR FAMILY HEALTH

Our office attracts and cares for families. We are interested in how their health background may affect you, and also in their specific concerns. Please note any health concerns you have knowledge of.

Name	Relationship	Past & Present Health Problems