



1002 King Street West. Toronto, ON M6K 3N2
416-597-1604 info@kingwestchiro.com

GENERAL PATIENT INFORMATION

Name: _____ Gender: M/F

Date of Birth: _____ (MM/DD/YY) Occupation: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: Home _____ Work: _____ Cell _____

Emergency Contact: _____ Tel: _____ Relation: _____

E-mail Address: _____ @ _____

Would you like to receive a reminder for your subsequent appointments? Email / Phone

How did you hear about our clinic? Please circle	Walk- in	Yellow Pages	Friend (who?) _____
	Website	Mailout	Brochure Other _____

Name of Medical Doctor: _____ Tel: _____

Address _____

Date of last appointment: _____ Date of last physical: _____

Are you taking any medications? If so, what? _____

Permission to consult with the above Health Care Providers Yes/No

I (please print name), _____ give permission to the discussion of any of the information in this form amongst the Health Care Team at King West Village Chiropractic Clinic.

Signature: _____ Date: _____

(guardian if under 18)



HEALTH HISTORY FORM

For your information:

An accurate health history is important to ensure that it is safe for you to receive chiropractic treatment. If your health status changes in the future, please let me know. All information gathered is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____

Today's Date: _____

Signature: _____

Date of Birth: _____

What is your primary complaint: _____

Please indicate conditions you are experiencing, or have experienced:

<p>Respiratory</p> <p><input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema</p> <p>Cardiovascular</p> <p><input type="checkbox"/> High or Low Blood pressure <input type="checkbox"/> Heart attack <input type="checkbox"/> Phlebitis <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Pacemaker or similar device <input type="checkbox"/> Heart disease <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Blood Clots or Clotting Disorder</p> <p>Infections</p> <p><input type="checkbox"/> Hepatitis <input type="checkbox"/> TB <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Skin <input type="checkbox"/> Other</p>	<p>Soft Tissue/Joint Discomfort and Its Nature</p> <p><input type="checkbox"/> Neck <input type="checkbox"/> Low Back <input type="checkbox"/> Mid back <input type="checkbox"/> Upper back <input type="checkbox"/> Shoulders <input type="checkbox"/> Elbows <input type="checkbox"/> Wrists / Hands <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Knees <input type="checkbox"/> Ankles / Feet <input type="checkbox"/> Legs <input type="checkbox"/> Muscle Cramping <input type="checkbox"/> Jaw <input type="checkbox"/> Weakness or Paralysis (where _____) <input type="checkbox"/> Other</p> <p>Head /Neck</p> <p><input type="checkbox"/> Vision problems <input type="checkbox"/> Ear problems (eg. fullness, ringing, loss) <input type="checkbox"/> Head Trauma <input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Past Whiplash Injury</p>	<p>Women</p> <p><input type="checkbox"/> Pregnant (due): <input type="checkbox"/> Menstrual Backache <input type="checkbox"/> Painful Periods <input type="checkbox"/> Birth Control Method: _____</p> <p>Other Conditions</p> <p><input type="checkbox"/> Loss of sensation <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Diabetes (onset): <input type="checkbox"/> Allergies <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <input type="checkbox"/> Arthritis (osteo or rheumatoid) <input type="checkbox"/> Spinal Conditions <input type="checkbox"/> Skin condition <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Disc Herniation <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Bone Disease</p> <p>What is your general health status?</p>
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Current Medications: _____

Condition it treats: _____

Recent Special Testing (blood work, x-rays, MRI etc) _____

Injuries / Fractures: _____

Surgeries: _____

Do you smoke? No Yes (how much _____) Do you exercise? No Yes (how often _____ Type _____)

Present involvement in other health care: No Yes If yes, what other therapy are you receiving _____

Other Medical Conditions (i.e. digestive conditions, gynecological conditions, hemophilia, emotional or mental illness etc.) _____

Of Special Note:(presence of internal pins, wires, artificial joints, special equipment): _____



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short-term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There have been reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustments is extremely remote;
- c) There have been reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific study evidence has demonstrated such injuries are caused, or may be caused by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

I understand that I am responsible for the fee of each treatment at the completion of each treatment.

A 24 hours notice is required to cancel an appointment, otherwise you will be billed a missed appointment charge.

Today's Date: _____

Patient Signature (Legal Guardian)

Name: _____
(please print)

Witness of Signature

Name: _____
(please print)