

**Glenmore Chiropractic – Chiropractic Care**  
**Confidential Patient Information**

Is this an ICBC/Worksafe injury?  Yes  No

If YES please note that we do NOT deal directly with ICBC or Worksafe for billing.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Primary Phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

**\*\*\*WE DO NOT DO PHONE REMINDERS. Your email address will ONLY be used for sending appointment reminder or to advise of changes at the clinic or with your appointments, insurance claim/account status or follow up for treatments. We will NOT share your email or any personal information with anyone. If you do not wish to receive email reminders please check this box ( ) If at any time you wish to be removed from our email list please notify the office by phone or email and we will remove you immediately.**

Employer: \_\_\_\_\_ Type of work: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female Marital Status:  M  S  D  W

Name of Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ BC MSP Care Card # \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

1. What is your main complaint(s)? \_\_\_\_\_
2. How did this condition begin?  Work injury  Sports injury  Auto accident  Home accident  
 Chronic (long-term) discomfort  Other (please describe) \_\_\_\_\_
3. How long have you suffered with this condition: \_\_\_\_\_ Day (s) \_\_\_\_\_ Week (s) \_\_\_\_\_ Month (s) \_\_\_\_\_ Year (s)
4. Have you experienced previous episodes of this condition?  Yes  No
5. Has this condition:  Gotten worse  Gotten better  Stayed constant  Comes & goes
6. Character of the condition:  Sharp  Dull  Achy  Burning  Numbness  Pins & needles
7. Intensity of the condition:  Mild  Moderate  Severe
8. Aggravating factors:  Sitting  Standing  Bending  Lifting  Walking  Lying  
 Other (please describe) \_\_\_\_\_
9. Relieving factors:  Bed rest  Ice  Heat  Medication  Massage therapy  
 Other (please describe) \_\_\_\_\_
10. Does this condition interfere with:  Work  Family  Sports/hobbies  Other: \_\_\_\_\_

Please complete other side....

FILE # \_\_\_\_\_

11. What other types of treatment have you tried:     Acupuncture     Medication     Physiotherapy     Massage Therapy  
 Other (please describe) \_\_\_\_\_

12. Have you seen a Chiropractor before?     Yes     No    If yes, Chiropractor's name: \_\_\_\_\_

Have you experienced any of the following in the past 6 months:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Visual problems         |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Allergies / hay fever | <input type="checkbox"/> Constipation / diarrhea |
| <input type="checkbox"/> Numbness/tingling        | <input type="checkbox"/> Heart problems        | <input type="checkbox"/> Blood Pressure problems |
| <input type="checkbox"/> Recurrent colds / flu    | <input type="checkbox"/> Digestion problems    | <input type="checkbox"/> Bladder problems        |
| <input type="checkbox"/> Hearing problems         | <input type="checkbox"/> Lung problems         | <input type="checkbox"/> Low energy / fatigue    |
| <input type="checkbox"/> Muscle weakness / cramps | <input type="checkbox"/> Thyroid condition     | <input type="checkbox"/> Jaw clicking / pain     |
| <input type="checkbox"/> Coldness in arms / legs  | <input type="checkbox"/> Sexual dysfunction    | <input type="checkbox"/> Menstrual problems      |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Diabetes              |  |

Please list any health conditions not mentioned: \_\_\_\_\_

Please list any medications (including pain): \_\_\_\_\_

Are you pregnant?             Yes             No     Unsure

Any past surgeries:             Yes             No    If Yes, list all \_\_\_\_\_

Any major accidents or falls?     Yes             No    If Yes, explain \_\_\_\_\_

Any auto accidents?             Yes             No    If Yes, when \_\_\_\_\_

**Informed Consent to Chiropractic Treatment .....**

*Please review and sign the attached consent for treatment in front of the doctor at your first appointment. For direct billing information please see receptionist. Payments for treatments are non-refundable.*

*Thank you.*

**RELIEF CARE**  
Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

**CORRECTIVE CARE**  
Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

**NOTES:**

## 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 tissues. 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.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **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 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\_\_\_\_