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 reminders or to advise of changes at the clinic or with your appointment; 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? □The Courier □ The Capital □Magazine □ Tv Ad □ Internet

□ Other (please describe)
_____

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:

□ Headaches	□ Sinus problems	□ Visual problems
□ Dizziness	□ Allergies / hay fever	□ Constipation / diarrhea
□ Numbness/tingling	□ Heart problems	□ Blood Pressure problems
□ Recurrent colds / flu	□ Digestion problems	□ Bladder problems
□ Hearing problems	□ Lung problems	□ Low energy / fatigue
□ Muscle weakness / cramps	□ Thyroid condition	□ Jaw clicking / pain
□ Coldness in arms / legs	□ Sexual dysfunction	□ Menstrual problems
□ Cancer	□ 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 doctorat 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.

_____ Date: _____ 20____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor