

### CONFIDENTIAL PATIENT INFORMATION SHEET

NP # \_\_\_\_\_

Please complete FULLY and accurately.

OFFICE USE ONLY

#### PERSONAL HISTORY

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal code: \_\_\_\_\_  
 Tel: Home \_\_\_\_\_ Business or Cell (circle) \_\_\_\_\_  
 Where do you wish to be contacted? (check) Home Business Cell  
 Occupation: \_\_\_\_\_ Marital status: \_\_\_\_\_ # of children \_\_\_\_\_  
 Family Dr (Name & Tel.): \_\_\_\_\_  
 Emerg contact (Name, Tel. & Relationship): \_\_\_\_\_

#### How were you referred to this clinic?

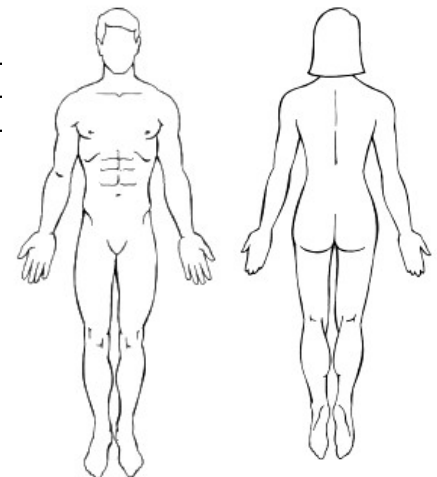
Yellow Pages \_\_\_\_\_ Friend/family (specify) \_\_\_\_\_  
 Massage Therapist or Naturopath \_\_\_\_\_ Health/injury talk \_\_\_\_\_  
 Advertising/pamphlet \_\_\_\_\_ Other (please specify) \_\_\_\_\_

Is this a **Workplace Safety & Insurance Board injury (WSIB)**? N Y  
 Are your injuries related to a **Motor Vehicle case**? N Y

#### CURRENT HEALTH HISTORY

Current complaint(s) – in order of importance to you

1) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_



On the drawings to the right mark all painful areas with an X

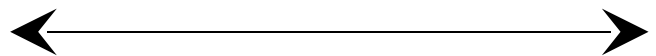
#### Describe the pain:

- |                  |               |
|------------------|---------------|
| Sharp & stabbing | Burning       |
| Pins & needles   | Dull, ache    |
| Numb             | Stiff & tight |

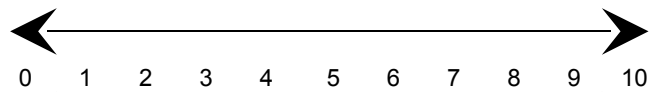
How long have you had this injury? \_\_\_\_\_  
 Have you had it before? N Y

Previous Chiropractic care? N Y Reason for treatment: \_\_\_\_\_

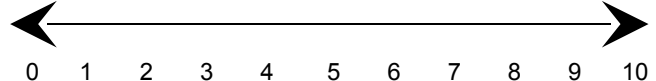
Circle your level of **Pain/discomfort**  
 (0 = no pain, 10 = worst pain)  
 0 1 2 3 4 5 6 7 8 9 10



Circle your general level of **Stress**  
 (0 = low stress, 10 = high stress)



Circle your level of **Commitment**  
 to correcting the problem  
 (0 = low level, 10 = high level)



Current **exercise routine** (type of activity, frequency, duration): \_\_\_\_\_

List any **medications, supplements** (vitamins, etc) that you are currently taking: \_\_\_\_\_

Do you wear Orthotics? N Y - If YES, how long have you had them? \_\_\_\_\_  
Are you a smoker? N Y - If YES, \_\_\_\_\_ cigarettes/day for \_\_\_\_\_ years  
Do you drink? N Y - If YES, \_\_\_\_\_ glasses per week  
Personal satisfaction with diet? Highly satisfied Satisfied Dissatisfied  
FEMALES ONLY: Are you pregnant? N Y  
Sleep: Hours per night \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### FAMILY HEALTH HISTORY

Have you or anyone in your family had the following (specify whom):

Heart disease \_\_\_\_\_ High blood pressure \_\_\_\_\_  
Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_  
Stroke \_\_\_\_\_ Other diseases \_\_\_\_\_

### PAST HEALTH HISTORY

List any previous **Surgeries** and the year(s) they occurred

\_\_\_\_\_ Year \_\_\_\_\_ Year \_\_\_\_\_

List any previous **Fractures** and the year(s) they occurred

\_\_\_\_\_ Year \_\_\_\_\_ Year \_\_\_\_\_

List any previous **Accident / traumas** and the year(s) they occurred

\_\_\_\_\_ Year \_\_\_\_\_ Year \_\_\_\_\_

### GENERAL HEALTH INFORMATION

Please check the symptoms you have experienced in the **past 6 months**

#### HEAD AND NECK

Headache	Neck pain	Hearing problems	Ringing in the ears
Sinusitis	Vertigo/ Dizziness	Eye problems	Vision problems
Nose problems	TMJ (jaw pain)	Sore throat	Voice changes

#### CHEST, LUNG, HEART, AND SKIN

Chest pain	Palpitations (heart)	Blood pressure problems	Allergies
Insomnia	Night sweats	Lung problems	Shortness of breath
Asthma	Skin problems	Restlessness, irritability	

#### DIGESTIVE SYSTEM AND MISCELLANEOUS

Nausea, vomiting	Heartburn	Poor appetite	Loss of taste
Bloating	Diarrhea	Constipation	Abdominal pain
Gas, rumbling	Hemorrhoids	Frequent weight change	Bruising easily

#### LIVER AND GALL BLADDER

Liver problems	Sweaty palms	Sweats easily	Irritated easily
Brittle nails	Bitter taste in mouth	Muscle cramps	Anxiety
Slow digestion	Tension headaches	Stiff joints and muscles	Restlessness

#### KIDNEY, URINARY TRACT, ENDOCRINE SYSTEM AND VARIOUS

Kidney stones	Urinary bladder problems	Kidney problems	Prostatitis
Frequent urination	Urinary tract infections	Incontinence	Feeling cold/hot
Feeling low energy	Low back pain	Joint pain	Weak or sore knees

#### GYNECOLOGICAL SYSTEM (WOMEN ONLY)

Painful periods	Heavy periods	Irregular periods	Long periods
Absent periods	Hot flashes	Endometriosis	Painful intercourse
Fertility problems	Pre-menstrual syndrome	Miscarriages, abortions	Breast problems

**OUR FEES**

Type of appointment	Adults	Seniors (65+), Students
Initial visit	\$75	\$50
Subsequent visit	\$32	\$29
Subsequent visit-extended visit	\$35	\$30
Chiropractic+ IFC or Ultrasound	\$40	\$35
Orthotics with Gait Analysis	Regular - \$400; Sandals, shoes - \$500	

**\*\*PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.**

Payment can be made by cash, cheque, debit, VISA/MC. If you cannot attend an appointment, please give **24 HOURS NOTICE** so that another patient may receive care during that time. I have read the above and understand that I am responsible for all charges relating to my visit.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**INFORMED CONSENT**

Doctors of Chiropractic, Medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments and manipulations are required to advise patients that there are some risks associated with such treatment. In particular, you should note:

- a) While rare, some patients have experienced muscle strain, ligamentous sprain and rib fracture following spinal adjustments or manipulation.
- b) There have been reported cases of injury to the vertebral artery (blood vessel located in the neck) following adjustment or manipulation to the neck. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment. The possibility of such injuries resulting from neck spinal adjustment or manipulation is extremely rare.
- c) There have been rare reported cases of disc injuries following neck or low back spinal adjustment or manipulation. However, scientific study has not supported that such injuries are caused, or may be caused, by spinal adjustments or Chiropractic treatment.

Chiropractic treatment, including spinal adjustment or manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years. These reports and studies have demonstrated Chiropractic treatment to be effective for spinal pain, headaches and other similar symptoms. Chiropractic care may contribute to your overall well-being. The risk of injuries or complications from Chiropractic treatment is substantially lower than that associated with other treatments, medications and procedures given for the same symptoms.

I acknowledge, I have discussed or have had the opportunity to discuss, with Dr. Scherer the nature and purpose of Chiropractic treatment in general and my treatment in particular as well as the contents of the consent.

I consent to the Chiropractic treatment offered or recommended to me by Dr. Scherer, including spinal adjustment. I am of legal age to give this consent.

Date \_\_\_\_\_

Print patient/guardian name

Signature of patient/guardian

Print name of witness

Signature of witness