The Queen Spadina Medical Centre
Confidential Chiropractic Client Information Form

(PLEASE PRINT CLEARLY)

NAME___________________________________ **GENDER:** □ male □ female

UNIT/APT #:______**ADDRESS:**____

CITY/TOWN:_______________**PROVINCE:**_________**POSTAL CODE**__________

PHONE #: residential (   )_____________**work: (   )**___________**ext:**_____________

Mobile:(   )_______________**e-mail address:**_________________________________

Please circle your preferred contact phone number where it will be permissible to leave messages regarding appointment times etc. if there should be need for such calls to be made.

Date of Birth:(dd/mm/yyyy)____________________**AGE:** ______________________

Who referred you to see the chiropractor/how did you find us?____________________

____

Primary Occupation:____

PARENTS AND GUARDIANS FOR THOSE UNDER 16 YEARS OF AGE:

I (print name)______________________________ have brought my child (named above) for an assessment and do hereby consent to allow a complete history and physical assessment on my child as a part of a diagnostic process to determine if and how the chiropractor may be of aid to his/her current health.

Background Information

Is your visit regarding a ***work related injury***? □ Yes □ No

Do you know your claim number? ____

Is your visit regarding an injury incurred during a ***motor vehicle accid***ent? □ Yes □ No

Have you already consulted someone about your current complaint? □ Yes □ No

If yes, who did you see?:____

Have you had any ***advanced imaging***? **Xray** □ Yes □ No **CT Scan** □ Yes □ No **MRI** □ Yes □ No

If so, when and at what facility:____

Do you have extended health benefits? □ Yes □ No

Have you seen a chiropractor before? □ Yes □ No Chiropractor's Name:____________________________

Date of last treatment:______________________ Describe your treatment and benefits:_______________

____

Medical Doctor's Name: __________________________Phone number: ____________________________

What is your reason for wanting to see the chiropractor today?:_____________________________________

____

What are your treatment expectations/goals:____

____

Primary Complaint

When did the problem begin?____

How did the problem begin?____

____

Describe the ***location*** of your problem:____

____

Does the pain stay ***localized or extend to other regions***? If so where?:_________________

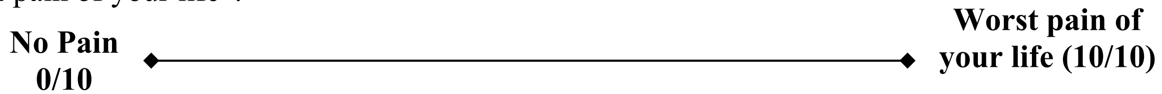
____

Describe the ***quality*** of the pain? Check all that apply:

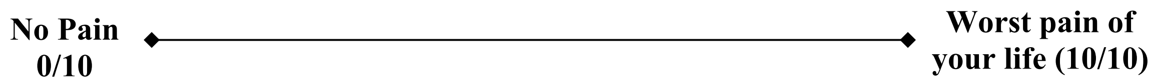
☐	Sharp	☐	Local	☐	Sore	☐	Tingling
☐	Stabbing	☐	Diffuse	☐	Stiff	☐	Weak
☐	Throbbing	☐	Aching	☐	Pulling	☐	Electric
☐	Dull	☐	Shooting	☐	Numb		

Other:________________________

Please draw a line on the diagram below to indicate how intense your pain is ***right now*** from "no pain" to "worst pain of your life".



Please draw a line on the diagram below to indicate how intense your pain is ***at it's worst*** from "no pain" to "worst pain of your life".



The pain: ☐Is Constant ☐Comes and Goes Predictably ☐Comes and Goes Unpredictably

Since the problem started is it: ☐Getting better ☐Staying the same ☐Getting worse

What makes your symptoms ***better***?: ☐Rest ☐Heat ☐Ice ☐Activity ☐Sitting ☐ Standing ☐Lying Down ☐Movement/Exercise ☐Inactivity ☐Nothing ☐Other_____________________

What makes your symptoms ***worse***?: ☐Rest ☐Heat ☐Ice ☐Activity ☐Sitting ☐ Standing ☐Lying Down ☐Movement/Exercise ☐Inactivity ☐Nothing ☐Other_____________________

Have you had any treatment for the complaint so far? ☐ Yes ☐ No

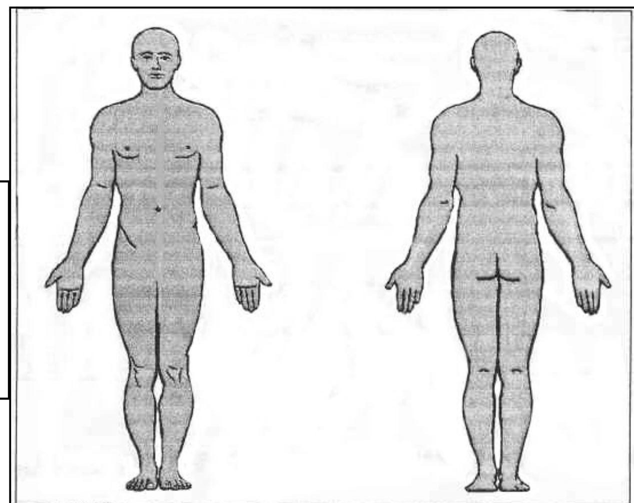
If yes please decribe:________________________

____

____

____

Please mark an X in the areas that you are experiencing your pain.



General Health

Exercise

Do you exercise regularly? □Yes □ No
What types?____
How often and how long per session? ____

Nutrition

Do you eat a balanced diet? □Yes □ No
Are you on a special or restrictive diet? □Yes □ No
If so, why? ____
Do you partake in fasts, or detoxification diets? □Yes □ No
If so why? ____
Do you consume alcohol? □Yes □ No How many beverages per week? ________
Do you consume coffee? □Yes □ No How many cups per day on average? ________
Do you smoke? □Yes □ No How much? ____ packs/day How many years?______
Have you had an unintentional weight loss or gain of greater than 10 pounds in the last year?: □Yes □ No

Sleep

How many hours of sleep do you normally get in a night?:___________________
Do you feel well rested after sleeping?:□Yes □ No
If not why?:____
What position do you sleep in?: □Left side □Right side □Back□ Stomach
Do you have pain when you wake up? □Yes □ No
If so where?:_____________________________ and for how long after you awake ________ hrs.

Life and Stress

Are there any significant stressors in your life? □Yes □ No
If so please list them here:____
Do those stressors impact on your health? □Yes □ No if so, how __________________________________
____

Drugs Supplements etc.

Do you take any regular prescription medications? □Yes □ No
If so what medications, and what dosage?____
Do you take any supplements? □Yes □ No
If so what supplements and what dosage?____
Do you take and non-prscription drugs? □Yes □ No
What drugs, dosage and regularity?____

Medical History

Hospitalizations, surgeries, fractures, major injuries?

Year	Hospitalization, illness, surgery	Outcome
_______	_______________________________________	______________________
_______	_______________________________________	______________________
_______	_______________________________________	______________________
_______	_______________________________________	______________________
_______	_______________________________________	______________________

Do you have any other conditions that you think the chiropractor should be aware of at this time?
____
____
____
____

Other Medical Conditions and Family History

Please indicate by entering a ✓ in the appropriate boxes to indicate that you currently have the condition, that you have had it in the past, or that you have it in your family history

CARDIOVASCULAR AND RESPIRATORY SYSTEMS

Condition	Currently	In the Past	In the Family
High blood pressure	□	□	□
Low blood pressure	□	□	□
Heart disease	□	□	□
Heart attack	□	□	□
Stroke	□	□	□
High cholesterol	□	□	□
High heart rate	□	□	□
Low heart rate	□	□	□
Clotting problems	□	□	□
Angina (chest pain)	□	□	□
Poor Circulation	□	□	□
Varicose Veins	□	□	□
Shortness of breath	□	□	□
Chronic cough	□	□	□
Spitting blood	□	□	□
Asthma	□	□	□
Fever	□	□	□
Chronic Fatigue	□	□	□
Other (indicate below)	□	□	□

MUSCULOSKELETAL SYSTEM

Condition	Currently	In the Past	In the Family
Low back pain	□	□	□
Mid back pain	□	□	□
Neck pain	□	□	□
Pain between shoulders	□	□	□
Arm/leg pain	□	□	□
Hip or shoulder problems	□	□	□
Knee or elbow injuries	□	□	□
Flat Feet	□	□	□
High arches	□	□	□
Hand problems	□	□	□
Arthritis	□	□	□
Rheumatoid Arthritis	□	□	□
Walking problems	□	□	□
Difficulty Chewing	□	□	□
Jaw Clicking	□	□	□
Myofascial Pain Syndrome	□	□	□
Fibromyalgia	□	□	□
Osteoporosis	□	□	□
Other (indicate below)	□	□	□

NERVOUS SYSTEM

Condition	Currently	In the Past	In the Family
Numbness/tingling	□	□	□
Shooting pain	□	□	□
Fainting	□	□	□
Convulsions	□	□	□
Multiple Sclerosis	□	□	□
Paralysis	□	□	□
Confusion	□	□	□
Dizziness	□	□	□
Depression	□	□	□
Headaches	□	□	□
Migraines	□	□	□
Sweats/tremors	□	□	□
Mental Illness	□	□	□
Alzheimer’s Disease	□	□	□
Parkinson’s Disease	□	□	□
Other (indicate below)	□	□	□
Change in appetite	□	□	□

GASTROINTESTINAL AND UROGENITAL SYSTEMS

Condition	Currently	In the Past	In the Family
Digestive Problems	□	□	□
Frequent Nausea	□	□	□
Ilitis or Colitis	□	□	□
Chronic Diarrhea	□	□	□
Chronic Constipation	□	□	□
Irritable bowel syndrome	□	□	□
Excessive Gas	□	□	□
Gall bladder Problems	□	□	□
Liver problems	□	□	□
Hemorrhoids	□	□	□
Hernias	□	□	□
Frequent Urination	□	□	□
Frequent Urinary Infections	□	□	□
Diabetes	□	□	□
Kidney Stones	□	□	□
Kidney Infections	□	□	□
Sexual dysfunction	□	□	□
STDs	□	□	□
Other (indicate below)	□	□	□

MEN

Condition	Currently	In the Past	In the Family
Benign Prostatic Hypertrophy	□	□	□
Other (indicate below)	□	□	□

WOMEN

Condition	Currently	In the Past	In the Family
Endometriosis	□	□	□
Menstrual Irregularities	□	□	□
Infertility	□	□	□
Miscarriage	□	□	□
Fibrocystic Breats	□	□	□
Uterine Fibroids	□	□	□
PID	□	□	□

Currently on birth control? Y□N□

What type? ________________

For how long?________________

children ________________

pregnancies______________

Condition	Currently	In the Past	In the Family
Other (indicate below)	□	□	□

EYES EARS NOSE AND THROAT

Condition	Currently	In the Past	In the Family
Visual Problems	□	□	□
Frequent sinusitis	□	□	□
Frequent ear infections	□	□	□
Hearing difficulties	□	□	□
Ringing in the ears	□	□	□
Dental problems	□	□	□
Altered sense of smell	□	□	□
Altered sense of taste	□	□	□
Other (indicate Below)	□	□	□

OTHER IMPORTANT QUESTIONS

Condition	Currently	In the Past	In the Family
Cancer	□	□	□

Type(s):____________________

Outcome: ___________________

Condition	Currently	In the Past	In the Family
Disc prolapse	□	□	□
Other Arthritides:	□	□	□

Type(s):____________________

Outcome: ___________________

Anything you feel is important that has not yet been asked…

____

____

____

____

____

____

____

Any information that you would like to add regarding answers of “other” may go here:____________________________

____

____

____

____

CONSENT FOR COLLECTION AND MAINTENANCE OF PERSONAL INFORMATION

I understand that to provide me with health care services, The Queen Spadina Medical Centre will collect some personal information about me (e.g., name, home contact information, social insurance number, health history, health measurements, samples or examination results, health conditions, assessment results, diagnoses etc.).

I understand that I am free at to examine the Queen Spadina Medical Clinic's privacy policy, and that although information within the clinic may be viewed by each health care provider that is involved in my care in order to increase the quality and continuity of that care, it will be held within the clinic protecting my privacy to the extent that governing legislation will allow. I understand how the Privacy Policy applies to me and understand that I have the right to ask questions regarding that policy.

I understand that only if I check off the following box and enter my contact phone number will I receive calls or phone messages regarding appointments, billings or other questions regarding my care.

☐ I allow The Queen Spadina Medical Centre to call and/or leave phone messages regarding my care at the following phone number: _____-_____________.
(Insert phone number)

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments that are beyond our control.

I consent to The Queen Spadina Medical Centre collecting, using and disclosing personal information about me as set out above and in the Queen Spadina Medical Centre's Privacy Policy.

SIGNATURE: _________________________________ DATE:______________________

PRINTED NAME: ____

WSIB Statement (if this is a WSIB claim)

I _________________________________, a chiropractic patient at the Queen Spadina Medical Centre (QSMC) understand that although my current condition is due to a work related injury, there is a remote chance that the WSIB will not accept my claim nor pay for my treatment. I understand that if the WSIB should choose to decline my claim that I will be responsible to reimburse the QSMC for all fees for services rendered as per the normal chiropractic fee guidelines.

Additionally, if I choose to continue to come to QSMC as a chiropractic patient after the closure of the current WSIB claim, I will be required at that time to pay the normal fees for services on the days that they are rendered.

Dated this__________day of ___________, 20_____.

______________________ ______________________
Print patient/ guardian name Signature of patient/ guardian

CONSENT TO CHIRORPACTIC TREATMENT

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:

> While rare, some patients have experienced muscle strain, ligamentous sprain and rib fracture following spinal adjustments or manipulation;
>
> There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote
>
> There have been rare reported cases of disc injuries diagnosed following neck or low back spinal adjustment or manipulation. However, scientific study have not supported that such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment. As such it is possible that those injuries pre-dated the treatment, but had not yet been diagnosed.

Soft tissue therapies may result in some local discomfort and bruising, but are commonly an important part of treatment plans to aid in the resolution of conditions commonly dealt with by chiropractors.

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 back and neck 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 my chiropractor 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 my chiropractor, including spinal adjustment. I am of legal age to give this consent.

Dated this__________day of ___________, 20_____.

_________________________ Print patient/ guardian name

__________________________ Signature of patient/ guardian