**Complete Balance Health Centre**
2896 Bloor Street West
Toronto, ON, M8X 1B5
(416) 769-1163

Today's Date: _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **First Name** | | | | **Last Name** | | | |
| **Address** | | | | **City** | | **Postal Code** | |
| **DOB** | | | | **Occupation** | | | |
| **H Telephone** | | **Cell** | | | **W Telephone** | | |
| **Email** | | | | | | | |

**Physician: _____ Address: _____ Phone: _____**
**Employer: _____**
**How did you hear about us? ☐Friend ☐Internet ☐Signage Other: _____**
**Name of Guardian if Applicable: _____**
**Emergency Contact: _____ Relation: _____ Phone: _____**

| **Do you have a family history of:** | | | | | |
|---|---|---|---|---|---|
| Cancer | **YES** | **NO** | Heart disease/stroke | **YES** | **NO** |
| Diabetes | **YES** | **NO** | Allergies | **YES** | **NO** |
| | | | Other(s)_____ | | |

**Lifestyle:**
Special Interest:_____ Sports:_____
Hobbies:_____ Health Goal: _____
Number of Hours per Week: _____

☐Coffee ☐No ☐Yes _____ cups/day
☐Tea ☐No ☐Yes _____ cups/day
☐Cigarettes ☐No ☐Yes _____ x/day
☐Alcohol ☐No ☐Yes _____ x/week
☐Exercise ☐No ☐Yes _____ x/week

What type of exercise:_____
_____
Vitamins/ Herbal Supplements? ☐No ☐Yes
What type and dosage:_____
_____

**Mental health:**
☐stress
☐depression
☐bipolar
☐others: _____

**What level of care are you interested in pursuing?**
☐symptom relief only
☐preventative and maintenance care

**Have you received the following services before?**
☐massage therapy
☐naturopathy
☐foot care
☐ psychotherapy
☐ physiotherapy
☐ orthotics

**Have you been to a chiropractor before? Yes / No If yes when? _____**

**Results: (please circle) Excellent Good Fair Poor Dr.'s Name _____**

**Please indicate by circling any of the following conditions that are causing you a problem.**
**Please check any conditions that have given you problems in the past.**

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness or pain in legs, hands, arms
Allergies
Wheezing
Neuralgia

E.E.N.T
Failing vision
Near sightedness
Far sightedness
Crossed eyes
Eye pain
Deafness
Earache

E.E.N.T Cont'd
Ear discharge
Nose bleeds
Nasal obstruction
Hoarseness
Sore throat
Hay fever
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands

SKIN:
Skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives of allergy

RESPIRATORY:
Chronic cough
Spitting up blood
Spitting up phlegm
Chest pain
Difficulty breathing

CARDIOVASCULAR:
rapid beating heart
slow beating heart
High blood pressure
Low blood pressure
Previous heart stroke
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke

MUSCLE & JOINT:
Stiff neck
Back ache
Neck pain
Swollen joints
Painful tailbone
Foot trouble
Pain in shoulders

M & J Cont'd:
Hernia
Spinal curvature
Faulty posture
Arthritis

GENITOURINARY:
Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Kidney stones
Bed wetting
Inability to control urine
Prostate trouble

GASTROINTESTINAL:
Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Colon trouble

GASTRO Cont'd:
Constipation
Intestinal wounds
Liver trouble
Gall bladder trouble
Jaundice
Colitis
Pain over stomach
Hemorrhoids (Piles)
Bowel Movement:
How often: _____

FOR WOMEN ONLY:
Painful menstruation
Irregular cycle
Cramps or backache
Previous miscarriage
Congested breast
Lumps in breast
Menopausal symptoms
Excessive flow
Hot flashes
# of pregnancies____
# of abortions_____
# of miscarriages____

Currently pregnant? Y / N

HAVE YOUR EVER HAD ANY OF THE FOLLOWING DISEASES? IF SO, PLEASE INDICATE:

| | | | | |
|---|---|---|---|---|
| Aneurysm | High blood pressure | Hepatitis | Polio | Sleeping difficulty |
| Cancer | Heart condition | Fatigue | HIV | Psoriasis |
| Respiratory conditions | Diabetes | Arthritis | Osteoporosis | Pneumonia |

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Have you ever been knocked unconscious? Yes / No. If Yes, when and how
_____

Have you been treated for your current condition before: Yes/No. If Yes, please explain_____

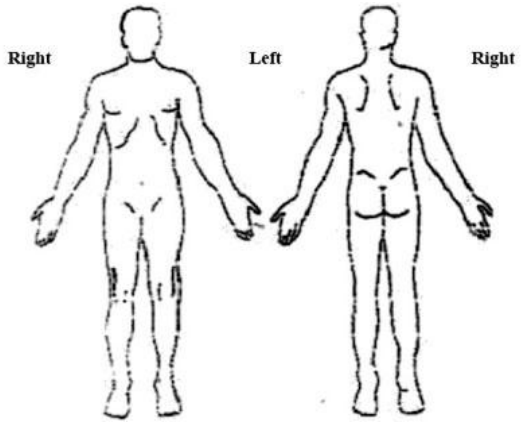
Are you presently taking any medication? Yes / No. If yes please list them:
_____

**Height: _____ Weight: _____**

**Pain Diagram**

**Indicate all areas of**

**////// Stiffness**
**●●●● Numbness**
**0000 Pins & Needles**
**✕✕✕ Burning**
****** Aching**
**††† Stabbing**



## Patient Questionnaire

**Accidents / Falls / Fractures / Dislocations (Please describe fully starting with most recent)**

_____

_____

**Have you had any surgeries? (please list starting with most recent)**

_____

**OVERALL HEALTH SURVEY**

1) Overall, how would you rate your health during the **past 4 weeks**?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very poor

2) During the **past 4 weeks**, how much did physical health problems limit your usual physical daily activities?

☐ none at all ☐ A little bit ☐ Some ☐ Quite a lot ☐ Could not do daily work

3) During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

☐ none at all ☐ A little bit ☐ Some ☐ Quite a lot ☐ Could not do daily work

4) How much bodily pain have you had during the **past 4 weeks**?

☐ none ☐ very mild ☐ mild ☐ moderate ☐ severe ☐ very severe

5) During the **past 4 weeks**, how much **energy** did you have?

☐ Very much ☐ Quite a lot ☐ Some ☐ A little ☐ none

6) During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?

☐ Not at All ☐ Very little ☐ somewhat ☐ quite a lot ☐ Could not do social activities

7) During the **past 4 weeks**, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

☐ Not at All ☐ slightly ☐ moderately ☐ quite a lot ☐ extremely

8) During the **past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

☐ Not at All ☐ Very little ☐ somewhat ☐ quite a lot ☐ Could not do social activities

Score: ____

1. Please rate the pain you are currently experiencing on a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain:

| **Area** | **Rating** | **Frequency** |
|---|---|---|
| **Head** | | **Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month☐Never |
| **Neck** | | **Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month☐Never |
| **Mid-Back** | | **Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month☐Never |
| **Shoulder R/L** | | **Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month☐Never |
| **Ribs** | | **Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month☐Never |
| **Low-Back** | | **Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month☐Never |
| **Other:** | | **Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month☐Never |
| **Other:** | | **Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month☐Never |
| **Other:** | | **Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month☐Never |

2. Does anything you do **aggregate** your condition (s): ☐**NO** ☐**YES**, if **yes**, what? _____
3. Does anything **relieve** your discomfort? ☐**NO** ☐**YES,** if **yes**, what? _____
4. Indicate the ability to perform the highlighted daily activities; please identify how your current condition is affecting you ability to carry out these activities.

| Activity | | No to little Effect | | | Painful (can do) | | | Painful (limits) | | | Unable to Perform | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bending | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Concentrating | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Doing computer work | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Gardening | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Playing Sports | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Recreation Activities | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Shoveling | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Sleeping | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Watching TV | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Carrying | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Dancing | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Dressing | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Lifting | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Pushing | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Rolling Over | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Sitting | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Working | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Climbing | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Doing Chores | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Driving | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Performing Sexual Activity | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Reading | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Running | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Sitting to Standing | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Walking | N/A | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

# CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

## Informed Consent to Chiropractic Treatment FORM L

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 are 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 the occurrence of stroke. Recent studies suggest 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 adjustment is extremely Remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal Adjustment, although no scientific 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.

**Dated this_____ day of_____, 20_____.**

_____ _____

**Patient Signature (Legal Guardian)** **Witness of Signature**

**Name:_____** **Name:_____**

**(Please print)** **(Please print)**