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. O = current √ = 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_____

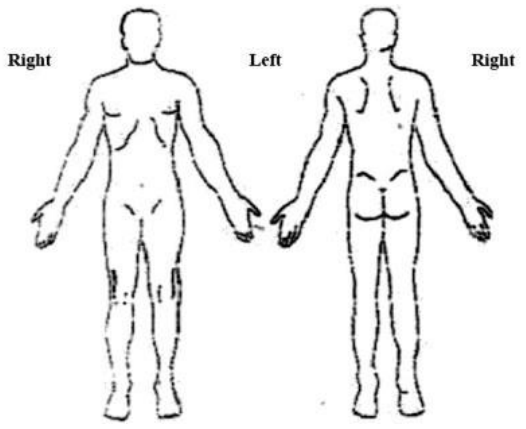
Are you presently taking any medication? Yes / No. If yes please list them:
_____

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 been diagnosed with other medical conditions?

_____

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**?

(very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

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?

0 1 2 3 4 5 6 7 8 9 10 (lots)

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

0 1 2 3 4 5 6 7 8 9 10 (lots)

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

0 1 2 3 4 5 6 7 8 9 10 (lots)

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

NAME: _____ DATE: _____

1. Please rate on the pain scale of **0** to **10** with **10** being the worst pain and **zero** being no pain. In the CURRENT RATING column please rate the pain that you are currently experiencing. Under frequency, please √ the box that applies.

Area	Current Rating	Frequency
Head	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Neck	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Mid-Back	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Shoulder R / L	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Ribs	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Low-Back	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never

2. Does anything you do **aggravate** your condition(s): ☐ **No** ☐ **Yes** If **yes,** what? _____
3. Does anything **relieve** your discomfort? ☐ **No** ☐ **Yes** If **yes**, what? _____
4. **P**lease identify how your current condition is affecting your 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

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 stiffnesswill 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)

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

_____ Date: _____20____
Signature of Chiropractor