

**Complete Balance Health Centre**  
 2862 Lakeshore Blvd West, 2<sup>nd</sup> floor  
 Toronto, ON, M8V 1H9  
 (416) 769-1163



Today's Date: \_\_\_\_\_

<b>First Name</b>				<b>Last Name</b>			
<b>Address</b>				<b>City</b>		<b>Postal Code</b>	
<b>DOB</b>				<b>Occupation</b>			
<b>H Telephone</b>		<b>Cell</b>		<b>W Telephone</b>			
<b>Email</b>							

**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	<b>YES</b>	<b>NO</b>	Heart disease/stroke	<b>YES</b>	<b>NO</b>
Diabetes	<b>YES</b>	<b>NO</b>	Allergies	<b>YES</b>	<b>NO</b>
			Other(s)	_____	

**Lifestyle:**

**Special Interest:** \_\_\_\_\_ **Sports:** \_\_\_\_\_

**Hobbies:** \_\_\_\_\_ **Health Goal:** \_\_\_\_\_

**Number of Hours per Week:** \_\_\_\_\_

<input type="checkbox"/> Coffee	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____ cups/day
<input type="checkbox"/> Tea	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____ cups/day
<input type="checkbox"/> Cigarettes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____ x/day
<input type="checkbox"/> Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____ x/week
<input type="checkbox"/> Exercise	<input type="checkbox"/> No <input type="checkbox"/> 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 ca

**Have you received the following services before?**

<input type="checkbox"/> massage therapy	<input type="checkbox"/> psychotherapy
<input type="checkbox"/> naturopathy	<input type="checkbox"/> physiotherapy
<input type="checkbox"/> foot care	<input type="checkbox"/> orthotics

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

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

# Chiropractic Intake Form

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

Aneurysm  
Cancer  
Respiratory conditions

High blood pressure  
Heart condition  
Diabetes

Hepatitis  
Fatigue  
Arthritis

Polio  
HIV  
Osteoporosis

Sleeping difficulty  
Psoriasis  
Pneumonia

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 \_\_\_\_\_

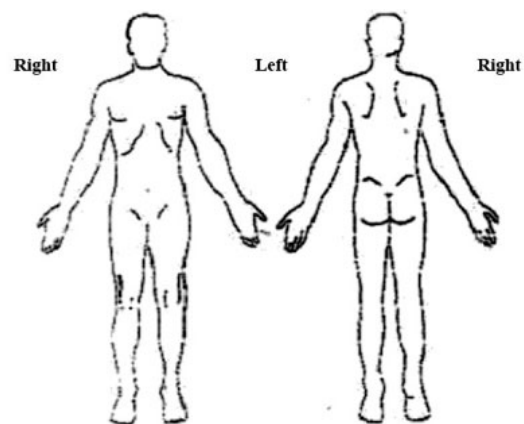
Are you presently taking any medication? Yes / No. If yes please list them: \_\_\_\_\_

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)**

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**Have you been diagnosed with other medical conditions?**

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

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**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

# Chiropractic Intake Form

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: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
Neck	/10	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
Mid-Back	/10	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
Shoulder R / L	/10	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
Ribs	/10	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
Low-Back	/10	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
Other:	/10	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
Other:	/10	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
Other:	/10	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> 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. Please 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 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.

## Chiropractic Intake Form

- **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)

\_\_\_\_\_  
Signature of patient (or legal guardian)

Date: \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Signature of Chiropractor

Date: \_\_\_\_\_ 20\_\_\_\_