Heartland Chiropractic

586 Centennial St. Winkler, Manitoba Ph. 331-3685

WELCOME TO OUR OFFICE

Prepared for:_____

To ensure your visit is a pleasant one, here are the procedures you can expect during the next 60 minutes.

Paperwork Complete this brief questionnaire and your health history form to help us get to know you. We will use this information to help formulate recommendations for your care.

Consultation You will meet the Doctor. The Doctor will review your history and determine if yours is a Chiropractic case. You will be informed of the cost of all office procedures before they are performed.

Examination Standard physical, orthopedic, neurological and Chiropractic tests will be performed to determine the cause(s) of your subluxation(s).

Spinal Image Necessary views may be taken to visualize the location of any spinal problems, neurological interferences, reveal any pathology and make your Chiropractic care more precise.

Correlation Before proper care can be rendered, the Doctor will study your examination findings. Later, you will view your x-rays, review your findings and receive specific care and recommendations from the Doctor.

CONFIDENTIAL PATIENT CASE HISTORY

GENERAL INFORMATION

☐ Miss ☐ Mrs. ☐ Ms. ☐ Mr. How would you like to be addressed? _____

Name _____Date _____

Address_____City _____Postal Code _____

Email _____Date of Birth _____Sex ☐ M ☐ F Age _____

D / M / Y

MHSC # (6 digit)_____ (9 digit) _____ **MPIC/WCB #** _____

Phone Home ( )_____ Work ( ) _____Ext._____ Cell/Other ( ) _____

Occupation/Profession _____ Employer _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of Children _____

Name(s) and Age(s) _____

_____

Name of Medical Doctor _____ Phone # _____

What is the major complaint for which you are seeking Chiropractic care? _____

Referred by: _____

Thank you. Again, we look forward to a healthy relationship with you!

Office Use Only:

Fee/Category

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system that have resulted in your lowered state of health. At your report of findings we will outline a course of care to correct these layers of damage and recover your innate health potential.

Present Health: Are you presently affected by any of the following (within the past 3 months)

O= Occasional F= Frequent C= Constant

Muscle and Joint	**O**	**F**	**C**
Backache	☐	☐	☐
Neck Pain	☐	☐	☐
Painful Tailbone	☐	☐	☐
Foot Trouble	☐	☐	☐
Shoulder Pain	☐	☐	☐
Hernia	☐	☐	☐
Spinal Curvature	☐	☐	☐
Faulty Posture	☐	☐	☐
Arthritis	☐	☐	☐
Stress Symptoms			
Headaches/Migraine	☐	☐	☐
Dizziness	☐	☐	☐
Numbness or pins& needles in arms/hands/legs/feet	☐	☐	☐
Ringing in ears	☐	☐	☐
Blurring of vision	☐	☐	☐
Loss of concentration / memory	☐	☐	☐
Irritable/Nervousness	☐	☐	☐
Depression	☐	☐	☐
Decreased energy /fatigue	☐	☐	☐
Tension	☐	☐	☐

General Symptoms	**O**	**F**	**C**
Fever/Chills/Sweat	☐	☐	☐
Fainting	☐	☐	☐
Convulsions	☐	☐	☐
Allergy	☐	☐	☐
Skin Problems	☐	☐	☐
Colds	☐	☐	☐
Tremors	☐	☐	☐
Loss of Balance	☐	☐	☐
Respiratory			
Chronic Cough	☐	☐	☐
Spitting phlegm/blood	☐	☐	☐
Chest Pain	☐	☐	☐
Difficulty breathing	☐	☐	☐
Urinary			
Painful Urination	☐	☐	☐
Up at night to urinate	☐	☐	☐
Blood in urine	☐	☐	☐
Increased urination	☐	☐	☐

Gastrointestinal	**O**	**F**	**C**
Difficult Digestion	☐	☐	☐
Belching or Gas	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Pain over Stomach	☐	☐	☐
Constipation	☐	☐	☐
Colon Trouble	☐	☐	☐
Liver Trouble	☐	☐	☐
Gall Bladded trouble	☐	☐	☐
Heartburn	☐	☐	☐
Diarrhea	☐	☐	☐
Bloody Stool	☐	☐	☐
Eyes/Ears/Nose/Throat			
Deafness	☐	☐	☐
Earache	☐	☐	☐
Sore Throat	☐	☐	☐
Asthma	☐	☐	☐
Sinus Trouble	☐	☐	☐

Cardiovascular	**O**	**F**	**C**
Rapid heart beat	☐	☐	☐
Slow heart beat	☐	☐	☐
High Blood Pressure	☐	☐	☐
Low Blood pressure	☐	☐	☐
Pain over heart	☐	☐	☐
Swelling ankles	☐	☐	☐
Previous heart attack	☐	☐	☐
Poor circulation	☐	☐	☐
Previous stroke	☐	☐	☐
Females Only			
Painful menstruation	☐	☐	☐
Excessive Flow	☐	☐	☐
Irregular	☐	☐	☐
Cramps/backache	☐	☐	☐
Abnormal discharge	☐	☐	☐
Passed menopause	☐	☐	☐
Pregnant	☐	☐	☐
Birth Control Pill	☐	☐	☐
No. of miscarriages	☐	☐	☐

Date of last menstrual period _____

Past Health: Have you ever suffered from any of the following?

	Yes	**No**
Thyroid Trouble	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Allergies	☐	☐

	Yes	**No**
Tuberculosis	☐	☐
Pneumonia	☐	☐
Back Pain	☐	☐
Headaches	☐	☐
Stomach Ulcers	☐	☐

	Yes	**No**
Emotional problems	☐	☐
Epileptic seizures	☐	☐
Asthma	☐	☐
Arthritis	☐	☐
Alcoholism	☐	☐

	Yes	**No**
Psoriasis	☐	☐
Polio	☐	☐
Cancer	☐	☐
Venereal Disease	☐	☐
HIV	☐	☐

Please list any significant illnesses, operations, accidents, falls or traumas below

Date	**Illness/Operation/Accident/Falls**

Informed Consent to Chiropractic Adjustments and Care

Chiropractic has only one goal, the correction of Vertebral Subluxation. To prevent confusion and disappointment, it is important that every person who starts care understands both the objective and the method that will be used to attain it. The Chiropractic objective is to analyze the spine, locate and correct Vertebral Subluxations. The Chiropractic method of correction is by specific adjustments of the spine. These adjustments are intended to correct Vertebral Subluxations over time, thereby allowing the innate healing abilities of the body to work at maximum efficiency. As in all health care, there are some associated risks to treatment, including but not limited to muscle sprains and strains, disc injuries, and very remote possibility of stroke or stroke like symptoms. Tests have been performed to minimize these risks to you. Chiropractic is considered one of the safest and most effective forms of treatment for Vertebral Subluxations.

I have read the above statement and consent to treatment.

Signature_____ Date _____

Thank you for completing this form. We certainly hope that we can help you attain health.

Heartland Chiropractic

Informed Consent to Chiropractic Treatment

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 rather, recent studies indicate 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.

Please read the above information and then initial the boxes below before signing at the bottom of the form. <u>Signing without initialing the boxes makes the forms invalid.</u>

☐ 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 consent to the adjustment of the spine, or any extremities and for examination of the area of complaint as a form of chiropractic treatment, in Heartland Chiropractic by Dr. Denise Vicari, D.C., or any other practitioner she chooses to have in her office.

☐ I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____ _____

Print Patient's Name Signature of Patient/Guardian

_____

Signature of Doctor