

NEW PATIENT QUESTIONNAIRE (2 PAGES NEED TO BE COMPLETED)

1. COMPLETE THIS PAGE

2. MEDICAL HISTORY

Name:

(First) (Middle) (Last)
Address: _____

Postal Code: _____ Birth date: _____ | _____ | _____ Sex: F M
(Month) (Day) (Year)

Phone number: Home: _____ Cellular: _____ Work: _____
Please circle which telephone number you would prefer to be contacted at.

E-mail address: _____ Personal health #: _____

Employer: _____ Nature of Work: _____

Who may we thank for referring you to our office? _____

Informed Consent to Chiropractic Care

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are, or may be some risks associated with such treatment.

In particular you should note:

- While rare, some patients have experienced rib fractures or muscle and ligament strains or sprains following spinal adjustments.
- There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote.
- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although scientific study has never demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years, and has been demonstrated to be a highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or 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, (including spinal adjustments), as well as the content of this consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Patient signature (Legal Guardian)

Witness of Signature

date

IF THIS IS A WORK RELATED INJURY THROUGH WORKSAFE OR A MOTOR VEHICLE INJURY THROUGH ICBC, PLEASE ADVISE, AS YOU WILL NEED TO COMPLETE A DIFFERENT FORM. THANK YOU

