Active Living CHIROPRACTIC
FAMILY WELLNESS • ACUPUNCTURE • ORTHOTICS
DR. STEPHEN O'NEIL B.Sc. D.C. CCSP

☐ Dr. S. O'Neil ☐ Dr. S. Bracken ☐ Dr. G. Fuerth

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# CONFIDENTIAL PATIENT HEALTH HISTORY

Date: _____ File No.: _____

## Patient Information

Name: _____ Sex: ☐ Female ☐ Male

Address: _____

City: _____ Prov.: Ontario Postal Code: _____

H. Phone: (___) _____ Alt. Phone: (___) _____ Ext.: _____

Date of Birth: ____/____/____ Age: _____ Medical Dr: _____
yr mm dd

Spouse's name: _____ How did you hear about us?: _____

Contact Person (if different): _____ Phone: _____

Names & ages of children: _____

Student: ☐ Retired: ☐ Employer: _____ Occupation: _____

Is your condition due to:

A work related injury? If yes: Date of Accident: _____

An automobile accident? If yes: Date of Accident: _____ Claim No.: _____

Have you ever received chiropractic care? ☐ Yes ☐ No If yes:

Who: _____ When: _____

Like to be added to our email list ? If yes: email address _____

Please provide signature for consent to receive emails: _____

**I consent to ☐ Dr. O'Neil ☐ Dr. Bracken ☐ Dr. Fuerth to perform a physical examination _____ (Initial)**

## Insurance Information

Do you have Insurance Coverage with Blue Cross, Great West Life, Green Shield ?

If yes, please list companies below. A signed Consent Form is also required.

Ins. Co. 1.: _____ Ins. Co. 2.: _____

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|---|---|

# About Your Health

The human body is designed to be healthy. There are many events that occur and habits that we pick up throughout our lifetime that may not allow us to maximize the expression of our optimum health potential. Please take a moment now to fill out these few simple questions so that we might better understand your overall health picture and develop an appreciation of the layers of damage that may exist in your body which are helping to block your body's innate ability to be well and healthy.

## Symptoms and Ill Health

As the years go by and the layers of damage increase, it is common to begin to experience symptoms and random bouts of ill health until we are brought to our present state of health.

Present reason for consulting our office:

- ☐ Correction and prevention of existing problem?
- ☐ Maximizing personal and / or family health potential?

If you have a specific chief complaint, please describe briefly. *If not, please go to next page.*

_____

_____

How and when did this problem start? _____

_____

Does the pain radiate or travel anywhere else? _____

Is the problem... ☐ constant ☐ intermittent ☐ worse with movement
Is condition worse... ☐ in the A.M. ☐ in the P.M. ☐ no change

Is the condition interfering with...
☐ sleep ☐ work ☐ routine ☐ other _____

Is condition getting progressively worse? ☐ Yes ☐ No

Pain is... ☐ sharp ☐ dull ☐ throbbing
☐ aching ☐ shooting ☐ nagging ☐ other _____

What aggravates your condition / pain? _____

What relieves your condition / pain? _____

If your condition was treated in the past, please describe treatment and results. _____

_____

_____

Have you had x-rays taken of this area? ☐ Yes ☐ No

Secondary complaints? _____

_____

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## Health History

Have you ever or do you presently suffer from any of the following symptoms?
Please list present treatment and include any medications being taken. If none, check ☐

| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Ears ring | ☐ Stiff/painful neck | ☐ Nervousness |
| ☐ Depression | ☐ Tension | ☐ Fatigue | ☐ Sleep problems |
| ☐ Chest Pains | ☐ Heart/lung trouble | ☐ Digestive disorders | ☐ Menstrual problems |
| ☐ Numbness or pins & needles in arms | ☐ Numbness or pins & needles in legs | ☐ Cold feet/hands | ☐ Arthritis - where? |

Are there any other medication or treatment you are receiving? (include birth control pills)
If none, please check ☐

List any surgeries and include when? _____
If none, please check ☐

What side effects have you experienced from your medications or surgery? _____
If none, please check ☐

Do you suffer from or is there a family history of: If none, please check ☐

| | Heart Disease | Stroke | Cancer | Arthritis | Diabetes | High BP | Other |
|---|---|---|---|---|---|---|---|
| Self | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐_____ |
| Mother's Side | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐_____ |
| Father's Side | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐_____ |

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## About Your Care

Chiropractic provides three types of care. The first is Initial Intensive Care, which corrects the most recent layer of Spinal and Neurological damage. This care usually reduces or eliminates the symptoms. Then begins Reconstructive Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

## Events and habits

NEONATAL TO ADULT: Many problems have roots in early spinal and/or neurological damage.

| Yes | No | | Patient's Comments |
|---|---|---|---|
| | | 1. PREGNANCY: Did your mother.... | |
| ☐ | ☐ | Experience any falls /injuries during pregnancy? | |
| ☐ | ☐ | Experience distress during delivery? | |
| ☐ | ☐ | Experience any prolonged illness? | |
| | | 2. GROWING YEARS | |
| ☐ | ☐ | Were you taught how to care for your spine? | |
| ☐ | ☐ | Any notable falls? | |
| ☐ | ☐ | Any significant childhood injuries or illnesses? | |
| ☐ | ☐ | Any childhood surgeries | |
| ☐ | ☐ | Any prolonged medications? | |
| ☐ | ☐ | Mental or physical abuse? | |
| | | 3. ADULTHOOD | |
| ☐ | ☐ | Ever in a motor vehicle accident? | |
| | | If yes, When? | |
| | | Any trauma or symptoms? | |
| ☐ | ☐ | Any notable falls or injuries as an adult? | |
| ☐ | ☐ | Any bone fractures / surgery? | |
| ☐ | ☐ | Hobby or sports injuries? | |
| ☐ | ☐ | Smoke? | |
| ☐ | ☐ | Drink alcohol? | |
| | | ☐ Daily ☐ Weekends ☐ Sporadically | |
| ☐ | ☐ | Exercise regularly? | |
| | | ☐ Daily ☐ Weekends ☐ Sporadically | |
| ☐ | ☐ | Proper posture? | |
| ☐ | ☐ | Eat as healthy as you think you should? | |
| ☐ | ☐ | Are you or have ever been overweight? | |
| ☐ | ☐ | Occupational stress? | |
| ☐ | ☐ | Repetitive lifting / bending? | |
| ☐ | ☐ | Continuous sitting / standing? | |
| ☐ | ☐ | Extensive computer work? | |
| ☐ | ☐ | Physical stress? | |
| ☐ | ☐ | Mental stress? | |
| ☐ | ☐ | Other traumas or problems? | |
| | | Sleep posture - ☐ side ☐ back ☐ stomach | |

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# CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

## Informed Consent to Chiropractic Treatment FORM - L

CCPA09.08

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 following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or 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.

_____ _____

Date Signed | Print Name of Patient or Legal Guardian

_____ _____

Signature of Patient or Legal Guardian | Signature of Chiropractor

Dates Reviewed

Date _____ Signature _____ Chiropractor _____

Date _____ Signature _____ Chiropractor _____

Date _____ Signature _____ Chiropractor _____

Date _____ Signature _____ Chiropractor _____