



Chiropractic Adult Intake Form

Glow Health & Vitality New Practice Member

Today's Date *



Month Day Year

Name *

First Name Last Name

Alberta Health # *

Address *

Phone Number *

Street Address

Area Code Phone Number

City State / Province

Cell Phone Company

Postal / Zip Code

If you choose text reminders

Email *

I like appt reminders by: *

I like receiving clinic updates & newsletters: *

example@example.com

Email
Text

Yes, please!
No, thanks.

Date of Birth *



Month Day Year

Height *

Weight *

Shoe Size *

Gender *

Marital Status

of children

Occupation

Emergency Contact Name *

Emergency Contact Phone Number *

Is this a WCB or MVA claim?

Yes
No

How did you find out about Glow? *

If you were referred by a patient, please include their name.

Where do you feel your health is? *

1 2 3 4 5 6 7 8 9 10

Poor Health

Excellent Health

Where do you want your health to be? *

1 2 3 4 5 6 7 8 9 10

Poor Health

Excellent Health

How important is your health?

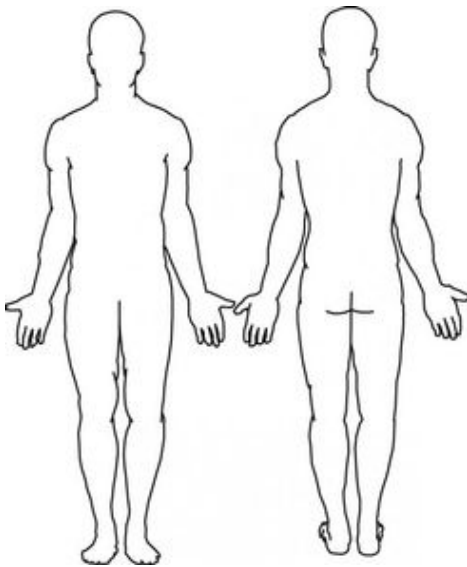
1 2 3 4 5

Not Really

Very

How long do you think it will take to get better?

Circle area or check box where you are experiencing discomfort:



- Head
- Jaw
- Neck
- Shoulders
- Chest
- Ribs
- Abdomen
- Hips
- Thighs
- Knees
- Calves
- Ankles
- Feet
- Upper back
- Mid back
- Lower back
- Glutes
- Arms
- Elbows
- Hands

Pain is mostly:

- Ache/aching
- Burning
- Numbness
- Pins & needles
- Stabbing/sharp

Please list all your medications, past & present:

Please list any family members with major illnesses:

Please list any serious injuries and surgeries, past & present:

Do you do any of the following?

- Drink bottled water
- Belong to a gym/health club
- Take vitamins
- Watch more than 5hrs of TV per week
- Use computer more than 1hr per day

- Drink soda
- Smoke cigarettes now or ever
- Drink alcohol now or ever
- Been in any serious accidents
- Play sports now or ever

Please rate your stress level at work: *

0 1 2 3 4 5

None

Extreme

Please rate your stress level at home: *

0 1 2 3 4 5

None

Extreme

Please list any major social or psychological stresses:

What do you do for stress relief?

How many hrs/week do you exercise?

Does this interfere with any of the following?

- Work
- Sleep
- Walking
- Hobbies/Leisure
- Other

Have you seen another practitioner for this?

Medical doctor, massage therapist, etc.

Any other health habits or needs we should know about?

Briefly tell us what brought you in today:

What best describes your health goals?

- Relief of symptoms
- Relief of symptoms, correction of underlying causes, prevention of re-occurrences
- Relief of symptoms, correction of underlying causes, optimizing long-term health

Please select any/all symptoms you have had

Past Present

Headaches
Neck pain
Back pain
Buzzing in ears
Finger numbness
Upset stomach
Irritability
Stiff neck
Diarrhea
Hot flashes
Urinary problems
Menstrual pain
Pins/needles in legs
Pins/needles in arms
Loss of balance
Ringing in ears
Toe numbness
Fatigue

issues with now or ever:

Past Present

Tension
Cold hands
Constipation
Cold sweats
Heartburn
Menstrual irregularity
Fainting
Loss of smell
Dizziness
Nervousness
Loss of taste
Depression
Sleeping problems
Cold feet
Fever
Eye sensitivity
Mood swings
Ulcers

Tell us how you hope to benefit from our care:

Very important Somewhat important No that important Does not apply

Physical improvement
Mental improvement
Stress improvement
Decision-making improvement
Quality of life improvement



Canadian Chiropractic Protective Association

Informed Consent to Chiropractic Treatment: Form L

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 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 in to 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 traveling 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 medical 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 and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

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.

Patient's Signature

Patient's Printed Name

Practitioner's Signature

Dated this day of



Month Day Year