

PERSONAL HEALTH PROFILE

Patient's Name (Including middle initial) _____ Date: _____

Address _____ Postal Code _____

Res. Phone _____ Bus. Phone _____ Cell _____ Age _____

Birthdate _____ Height _____ Weight _____ # of children _____ email _____

Occupation _____ Employer _____ Name of Spouse _____

Who referred you here or how did you learn of our office: _____

BC Care Card # _____

Do you currently qualify for premium assistance with the Medical Services Plan of BC yes no

Spinal subluxations have a significant impact on your health and well-being. Please answer the following important questions to the best of your ability, in as much detail as is practical.

Your Childhood History

Describe all childhood impacts, especially hard falls, sports or car accidents, concussions, broken bones etc.

Please describe all significant or chronic childhood illnesses: _____

Were you given any prolonged doses of medications, such as antibiotics or inhalers? _____

Did you suffer any significant emotional traumas as a child? _____

As a child, did you receive regular chiropractic care: _____ Doctor's name? _____

Your Current History

Briefly describe your chief complaint, its location and the effect it has had on your life: _____

How long has this problem been present? _____ Have you ever had this problem in the past? _____

If so, when? _____ What do you think is *the cause* of your problem? _____

If you are experiencing pain, is it: _____ sharp _____ dull _____ comes/goes _____ travels _____ constant

What makes the problem worse? _____ What makes it better? _____

What specific life activities does it interfere with (work, sleep, leisure etc?) _____

Is your complaint related to a motor vehicle accident? yes no Is it related to a Worker's Comp Injury? yes no

Other Doctors seen for this problem (please list)

Chiropractor _____ Medical Doctor _____ Other _____

On a scale of 1 – 10 describe your current stress level: (1= None / 10= extreme) Occupational _____ Personal _____

Please describe the following as either, poor, fair, good or excellent:

Diet _____ Exercise _____ Sleep _____ Posture _____ General Health _____

Have you had x-rays of your spine within the last years? _____ If so, where were they taken? _____

Most people have had literally dozens of impacts/stresses that can cause subluxations.

When was your most recent auto accident? _____ Front/side/rear-end collision? _____

Describe your most recent stress or strain during these activities? _____

What sport or recreational activities do you do? _____

When was your most recent stress or strain during these activities? _____

Is there any other injury that you have had, minor or major, that we should know about? _____

Please put a **“C”** beside each symptom which you **currently** have (or experience on a recurring basis):

Please put a **“P”** beside each symptom you have had in the **past**.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back pain | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Problem urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Breathing difficulty | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Sinus problems |

List all drugs (medications) you are taking: _____

List any chronic disease(s) you may have: (arthritis, diabetes, cancer, heart disease, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis etc.)

List all surgeries _____

Other comments:

The statements made on this form are true to the best of my memory and I agree to allow this office to examine me for further evaluation:

Signature: _____ Date: _____

Dr. Heidi Benda, BAA, DC
Power On Chiropractic
905 West 16th Street
North Vancouver, BC V7P 1R2
604-929-7700

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:
- b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasions result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, 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 the chiropractic treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatment offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature (and Legal Guardian)

Witness of Signature

Name (please print)

Name (please print)