TELL US ABOUT YOUR CONDITION

Lucknow Chiropractic & Wellness Centre
580 Campbell St
Lucknow, ON N0G 2H0
519-528-5083

Name: _____

Date: _____

File # _____

Major Complaints (In order of Severity), **Where does it hurt?** (low back, neck, left or right, headaches, etc)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____

How did the problem start (i.e. lifting, bending over, a fall, unknown)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

How long have you had each complaint? (days, weeks, months, years?)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____

Have you ever had an injury to this area before? (If so, when did it start?)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____

Describe what type of pain you feel (sharp, stabbing, dull, achy, numbness, tingling, burning)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____

What makes it better? (laying down, walking, sitting, standing, ice, heat, medications)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____

What makes it worse? (sitting, standing, bending, lifting, walking, reaching, coughing, ….)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____

Rate the severity of your pain from 0-10 (0 = no pain, 10 = most pain ever)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____

Is it worse at certain times of the day? (first thing in the morning, evening, during the day, or night)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____

What have you tried to make it better? (chiropractic, physio, massage, ice, heat, medication, other…)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____

PAST MEDICAL HISTORY FORM

Check the space below if you CURRENTLY have, or EVER have had the problem

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GENERAL
___ Chronic Fever
___ Chronic Chills
___ Night Sweats
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Weight Loss or Gain
___ Allergies
___ Diabetes
___ Cancer
___ Thyroid Disease
___ Alcoholism
___ Drug Abuse

EYES EAR NOSE THROAT
___ Poor Vision
___ Pain in Eyes
___ Deafness/Difficulty Hearing
___ Nosebleeds
___ Sinus Trouble / Ear Infections
___ Dental Problems
___ Hoarseness

GASTROINTESTINAL
___ Poor Appetite
___ Poor Digestion
___ Difficulty Swallowing
___ Belching or Gas
___ Frequent Nausea
___ Vomiting
___ Vomiting Blood
___ Pain over Abdomen
___ Ulcer
___ Black or Bloody Stools
___ Liver Problems
___ Gallbladder Problems
___ Jaundice
___ Hernia
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Appendicitis

WOMEN ONLY
___ Live Births
___ Miscarriage
___ Painful periods
___ Excessive Flow
___ Irregular Cycles
___ Vaginal Burning/Itching
___ Hot Flashes

HOSPITALIZATIONS
___ List date and reasons

RESPIRATORY
___ Difficulty breathing
___ Chronic Cough
___ Spitting Phlegm
___ Spitting Blood
___ Wheezing / Asthma
___ Pneumonia
___ Tuberculosis

CARDIOVASCULAR
___ Irregular heartbeat
___ High Blood Pressure
___ Chest Pain
___ Previous Heart Trouble
___ Ankle Swelling
___ Varicose Veins
___ Rheumatic Fever
___ Stroke

GENITOURINARY
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Disease
___ Urinary Infection
___ Inability to Control Urination
___ Difficulty Starting Urine Flow
___ Get up __ times per night to urinate
___ Breast Lump or Pain
___ Venereal Infection
___ Sexual Difficulties

SKIN
___ Itching
___ Bruising easily
___ Change in Mole(s)
___ Skin Cancer

NEUROLOGIC
___ Weakness
___ Twitching
___ Tremors
___ Headache
___ Fainting
___ Dizziness
___ Convulsions
___ Epilepsy
___ Numbness/Tingling
___ Arm/Leg Pain
___ Mental Disorder

MEN ONLY
___ Testicular
___ Prostate Problems

MUSCULOSKELETAL
___ Neck Pain
___ Mid Back Pain
___ Low Back Pain
___ Swollen Joints
___ Painful Joints
___ Muscle Soreness
___ Spinal Curvature
___ Arthritis

CHILDHOOD DISEASES
___ Mumps
___ Measles
___ Chicken Pox

SURGERIES
___ List date and reasons

MEDICATIONS
___ Prescription
___ Non-prescription

HABITS
___ Smoking ___Packs/day
___ Drinking
___ Recreational Drug Use

EXERCISE
___ None
___ 1-2 times/week
___ 3-5 times/week
___ 6-7 times/week

FAMILY HISTORY
___ Diabetes
___ Thyroid Disease/Goiter
___ Tuberculosis
___ Kidney Disease
___ High Blood Pressure
___ Heart Disease
___ Cancer
___ Muscle, Bone or Nerve Disease
___ Other

ACCIDENTS/TRAUMA
___ Motor vehicle accidents
___ Other trauma/accidents

PATIENT NAME _____

File Number _____ **Date** _____

LUCKNOW CHIROPRACTIC & WELLNESS CENTRE
www.lucknowchiropractic.com

580 Campbell St, PO Box 524, Lucknow, ON, N0G 2H0
drbrad@lucknowchiropractic.com, 519-528-5083, fax 519-528-5091

Consent to Chiropractic Treatment

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 disc 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 into 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 down 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 health 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 in and responsible for your care. Inform your chiropractor immediately of any change in your condition.
I understand I am solely responsible for payment of fees and charges regardless of private health insurance, MVA insurance claims, or WSIB claims.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

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.

_____
Name (Please Print)

_____ Date:_____20_____
Signature of patient (or legal guardian)

_____ Date:_____20_____
Signature of Chiropractor

I consent to the fabrication of **custom fitted foot orthotics** for a trial of therapy for the **minor listed below or myself.** Once ordered I am responsible for the payment of the orthotics, and realize I have thirty days to reconsider the benefit of the orthotic therapy. I have been given the option to inquire elsewhere for orthotics and realize the doctor has a financial interest in the fees paid.

_____ _____
Patient's Name Signature of Patient or Parent/Guardian

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Patient Information Sheet

Name:_____Date:_____

Date of Birth (MM/DD/YR)_____ Age: _____

Marital Status: (circle) Single Married Divorced Widowed Separated Common Law

Gender: Male ☐ Female ☐ Other ☐_____

Home Address: _____

City_____Province_____ Postal Code_____

Home Phone ( ) _____-_____ Cell ( ) _____-_____

Appointment Reminder: Phone ☐ Text ☐ Email ☐

Email address: (please print clearly) _____

Do you agree to accept our email communication? Yes _____ No _____

Contact Person _____
Contact Phone # _____
Spouse's Name _____

Children's Name(s) _____ _____
_____ _____
Occupation _____
Employer _____
Employer's Address _____

Employer's Phone # ( ) _____ - _____ Extended Health Coverage: Yes _____ No_____

How did you hear about us? Referred by:
_____

Website: ☐ Facebook: ☐ Instagram: ☐ Youtube: ☐ Google: ☐
Phone book: ☐ Yellow Pages ☐
Other(Specify)_____

Prior Chiropractic Care? Yes_____ No_____ X-rays taken: Yes_____ No_____

Family Doctor: _____ Phone #( ) _____ -_____

Will this claim be made against a recent Motor Vehicle Accident? Yes_____ or No _____
Or Workplace Injury? Yes_____ or No _____