Gordon Street Chiropractic Centre
403 Arkell Road, Unit #6
Guelph, ON N1L 1E5
Office: (519) 837-0411 Fax: (519) 780-1419

Date: _____ Doctor: _____

Personal History

Name _____ Address _____
Date of Birth _____ City _____
Home Phone _____ Province _____ Postal Code _____
Cell Phone _____ Email Address _____
Gender: ☐ Male ☐ Female Business Phone _____
Employer _____ Type of Work _____
Do you have extended health care insurance? ☐ Yes ☐ No
Circle one: Single Married Widowed Other
What are the names and ages of your children? _____
Name and Number of Emergency Contact: _____
Who may we thank for referring you? _____ or
☐ Phone book ☐Advertisement ☐Internet ☐Other: _____
Have you seen a chiropractor before? If so, who and when? _____
Was it for the same condition you are currently experiencing? ☐ Yes ☐ No

Current Health Condition

Area(s) of Complaint: _____
Other doctors seen for this condition: ☐ Yes ☐ No Who: _____
Type of treatment: _____ Results: _____
When did this condition begin? _____
Has this condition occurred before? ☐ Yes ☐ No How long ago? _____
Is your condition: ☐ Job related ☐ Auto-related ☐ Home injury ☐ Fall ☐ Other
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting
☐ Walking ☐ Lying ☐ Other: _____
What relieves your condition? ☐ Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____
Is it getting? ☐ Worse ☐ Constant ☐ Better ☐ Comes and goes
What time of day/night do you feel it the most? _____
Character of pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb
☐ Burning ☐ Constant ☐ Intermittent ☐ Shooting
☐ Other: _____

Please circle the number that describes how severe your pain is today?
Least 1 2 3 4 5 6 7 8 9 10 Worst

Compared to when you feel great, does having this condition interfere with your ability to:
☐ Work ☐ Enjoy family/friends ☐ Do fitness/play sports ☐ Other: _____

At its worst, how does it make you feel? _____
If you don't get this problem corrected, do you think it will get worse? ☐ Yes ☐ No

What is your biggest worry regarding this condition? _____
_____

What is most important to you with regards to your care at this office?

- ☐ Reduction in severity and frequency of symptoms
- ☐ Correction of the underlying cause of your problem
- ☐ Feeling the best and healthiest you ever have
- ☐ Increase in flexibility
- ☐ Better sports performance
- ☐ Increase in energy and vitality
- ☐ Increase in immune system function
- ☐ Other goals are: _____

Please list any current medications/supplements? _____
_____

Do you suffer from any condition other than that for which you are now consulting us?
_____

Have you had x-rays taken in the last 24 months? ☐ Yes, Where? _____ ☐ No

Have you had any hospitalizations, surgeries, injuries? Please list and include dates: _____
_____

Have you ever been in a car accident, however small? ☐ No ☐ Yes When: _____
_____

Circle the level of stress you are experiencing on a scale of 1 to 10:

Least 1 2 3 4 5 6 7 8 9 10 Most

What is the major cause of your stress? ☐ Health ☐ Work ☐ Family ☐ Financial
☐ Other: _____

NOTES:

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following conditions you have had:

- □ Measles
- □ Mumps
- □ Whooping Cough
- □ Chicken Pox
- □ Polio
- □ Rheumatic Fever
- □ Small Pox
- □ Influenza
- □ Pneumonia
- □ Tuberculosis
- □ Pleurisy
- □ Eczema
- □ Lumbago
- □ Anemia
- □ Mental Disorder
- □ Epilepsy
- □ Arthritis
- □ Diabetes
- □ Cancer
- □ Heart Disease
- □ Thyroid

Check any of the following if you had these conditions the last six months:

General

- □ Fatigue
- □ Allergies
- □ Loss of sleep
- □ Fever
- □ Headaches

Musculoskeletal Code

- □ Low back pain
- □ Pain between shoulders
- □ Neck pain
- □ Arm pain
- □ Joint pain/stiffness
- □ Walking problems
- □ Difficulty chewing

Nervous System Code

- □ Nervous
- □ Numbness
- □ Paralysis
- □ Dizziness
- □ Forgetfulness
- □ Depression
- □ Fainting
- □ Convulsions
- □ Cold tingling extremities
- □ Stress

CV Code

- □ Chest pain
- □ Short breath
- □ Blood pressure problems
- □ Irregular heart beat
- □ Heart problems
- □ Lung problems
- □ Varicose veins
- □ Ankle swelling
- □ Stroke

GI Code

- □ Gas/bloating
- □ Poor/excessive appetite
- □ Poor/excessive thirst
- □ Frequent nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Hemorrhoids
- □ Black/bloody stool
- □ Liver problems
- □ Gall bladder problems
- □ Weight trouble
- □ Abdominal cramps

GU Code

- □ Bladder trouble
- □ Painful / excessive urination
- □ Discoloured urine

Do you have a regular Exercise Routine

- □ Yes
- □ No

EENT Code

- □ Vision problems
- □ Dental problems
- □ Sore throat
- □ Ear aches
- □ Hearing difficulty
- □ Stuffed nose

Male/Female Code

- □ Menstrual irregularity
- □ Menstrual cramping
- □ Vaginal pain/infections
- □ Breast pain/lumps
- □ Prostate/sexual dysfunction

For Females

When was your last period?_____

Are you pregnant?

□Yes □ No □ Not sure

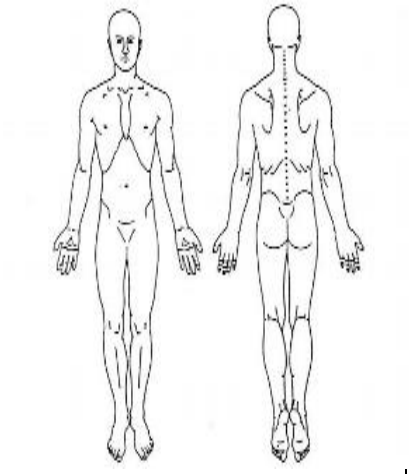
Intake Code

- □ Coffee
- □ Tea
- □ Alcohol
- □ Cigarettes

Dietary Satisfaction

- □ Highly satisfied
- □ Satisfied
- □ Dissatisfied
- □ Highly dissatisfied

Please outline on the diagram the area of your discomfort and any radiation of pain.



Informed Consent to Chiropractic Treatment

Consent to Examination

Your chiropractic care at this office will be based upon the details of your personal health history, as well as detailed orthopedic, chiropractic ad neurological and potentially x-ray examinations. During the course of these examinations the chiropractor will be asking you to bend, twist and move and undergo a physical examination in which the doctor will feel areas of your spine and muscles.
I have read the above and consent to undergoing the above listed examinations.

_____ _____ _____

Print name Signature Date

Consent to Treatment

Chiropractors locate, analyze and correct vertebral subluxations, which are misalignments of spinal joints, which cause nervous system imbalances. 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 can greatly contribute to your overall well-being and good health. Chiropractors utilize chiropractic adjustments, soft tissue therapy and occasionally modalities such as Ultrasound and Interferential current to treat your condition.

Chiropractic care is considered to be one of the safest forms of health care; the risk of injuries of complications from chiropractic treatment is substantially lower than that associated with medical or other treatment, medications and procedures given for the same symptoms. However, all treatment contains some risks you should be aware of. These include ligament sprains, muscle strains, rib fractures, and disc injuries. Additionally, cervical spine adjustments can carry the extremely remote complication of vertebral artery injury resulting in stroke. We will do our very best to minimize these risks through thorough examination and screening practices.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, my treatment in particular, and the risks associated.

I have read the above consent and by signing below I consent to chiropractic treatment at this office. I intend this consent to apply to all my present and future chiropractic care.

_____ _____ _____

Print name Signature Date

DC's initials_____