# Coquitlam Integrated Health

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## PATIENT INTAKE FORM

*(By filling out this form, it enables us to provide you with the most effective care. Thank you for your cooperation.)*

*Date of Visit:* _____

Full Name _____ I go by: _____
*(last)* *(first)*

Care Card (PHN #) _____ Male ☐ Female ☐

Birthday (mm/dd/yy) _____ Age: _____ Marital Status: S __ M __ D __ W __ L/W __

Spouse/Partner's Name: _____ Ages of children if any: _____

Address _____
*(Apt. No)* *(Street)* *(City)* *(Postal Code)*

Phone Numbers: _____
*(Home Phone)* *(Cell Phone)*

Email: _____ Reminder email? Yes ☐ No ☐

Occupation _____ Work Tel. _____

Company name: _____ May we call you at work? Yes ☐ No ☐

Your GP's Name (MD) _____ Tel. _____

*Emergency Contact (and relation):* _____ Tel. _____

Is your condition part of an ICBC or WCB claim? If YES, please indicate the following:

Adjuster's Name: _____ Tel. _____

Claim No: _____ Lawyer's Name/Tel: _____

Where did you hear about our clinic?

☐ Internet ☐ Yellow Pages ☐ Friend/Relative ☐ MD

☐ Other Practitioner *Name:* _____

***Cancellation Policy:*** *We set dedicated time in our office for all appointments. If you find it necessary to cancel, please provide 24-hour advance notice. Without notice, you will be charged 50% of the applicable treatment fee.*

☐ *Please initial once you have read*

**HEALTH ISSUES QUESTIONNAIRE:**

Main Concerns:

How long have you had this condition(s)?

Have you been given a diagnosis by your GP? If YES, what is that diagnosis?

Have you tried any of the following treatments before?

☐ Acupuncture ☐ Massage Therapy ☐ Chiropractic ☐ Laser Therapy

*Other treatments?*

**MEDICATIONS** (include prescriptions and over-the-counter/include dosage)

☐ Anti-inflammatory ☐ Muscle Relaxants ☐ Laxatives ☐ Anti-depressants

☐ Pain killers ☐ Sleeping pills ☐ Other ☐ Supplements (Herbs, gingko, other vitamins)

*Additional details:*

**MAJOR INJURIES AND ILLNESSES/ACCIDENTS/ALL SURGERIES** (indicate dates and nature of each)

**LIFESTYLE QUESTIONS (indicate with an X on a scale of 0 to 10: 0 – NONE ; 10 – HIGH)**

| | | | |
|---|---|---|---|
| Stress: | 0 1 2 3 4 5 6 7 8 9 10 | Exercise/week: | 0 1 2 3 4 5 6 7 8 9 10 |
| Smoke: | 0 1 2 3 4 5 6 7 8 9 10 | Alcohol: | 0 1 2 3 4 5 6 7 8 9 10 |
| Coffee: | 0 1 2 3 4 5 6 7 8 9 10 | | |

**FAMILY MEDICAL HISTORY**

| | | | | |
|---|---|---|---|---|
| ☐ Allergies | ☐ Cancer | ☐ Diabetes | ☐ Hepatitis | ☐ Thyroid Disease |
| ☐ Seizures | ☐ Heart Disease | ☐ Stroke | ☐ Venereal Disease | |
| ☐ Thyroid Disease | ☐ Varicose Veins | ☐ Rheumatic Fever | ☐ High/Low Blood Pressure | |

**FOR WOMEN ONLY**

Are you pregnant? YES / NO / MAYBE If YES, when is your due date? _____

Do you have children? YES / NO If YES, was it: Vaginal birth / Caesarean birth

Menstrual cycle: Regular / Irregular / Painful Cycle

Date of your last annual Pap/Breast exam: _____

**Review of systems** Please check the appropriate box for any of the following symptoms and add any comments you may feel are important.

Key: **P**=Past **N**=Now **B**=Both

**P N B**

**General**
☐☐☐ Insomnia
☐☐☐ Fatigue
☐☐☐ Weight loss
☐☐☐ Weight gain

**Head**
☐☐☐ Headache
☐☐☐ Dizziness
☐☐☐ Head trauma
☐☐☐ Fainting

**Eyes**
☐☐☐ Itching/redness
☐☐☐ Cataracts
☐☐☐ Flashes in vision
☐☐☐ Spots in vision
☐☐☐ Glaucoma

**Mouth and Throat**
☐☐☐ Bleeding gums
☐☐☐ Canker sores
☐☐☐ Colds sores
☐☐☐ Sore throat
☐☐☐ Jaw/TMJ problems
☐☐☐ Hoarseness
☐☐☐ Goiter

**Nose**
☐☐☐ Hayfever
☐☐☐ Loss of smell
☐☐☐ Nosebleeds
☐☐☐ Sinus problems

**Lungs**
☐☐☐ Shortness of breath
☐☐☐ Persistent cough
☐☐☐ Loss of smell
☐☐☐ Nosebleeds
☐☐☐ Sinus problems

**Vascular**
☐☐☐ Angina
☐☐☐ Murmurs
☐☐☐ Chest pain
☐☐☐ Palpitations
☐☐☐ Ankle swelling
☐☐☐ Cold feet/hands
☐☐☐ Leg cramps
☐☐☐ Varicose veins
☐☐☐ Low blood pressure
☐☐☐ High blood pressure

**P N B**

**Gastro-Intestinal**
☐☐☐ Bloating/gas
☐☐☐ Heartburn
☐☐☐ Ulcers
☐☐☐ Liver disease
☐☐☐ Gallstones
☐☐☐ Vomiting/nausea
☐☐☐ Abdominal pain
☐☐☐ Diarrhea
☐☐☐ Constipation
☐☐☐ Blood in stool
☐☐☐ Hemorrhoids
☐☐☐ Hernias
_____ # of bowel movements per day

**Gastro-Urinary**
☐☐☐ Difficulty urinating
☐☐☐ Pain urinating
☐☐☐ Blood in urine
☐☐☐ Incontinence
☐☐☐ Bed-wetting
☐☐☐ Frequent urination
☐☐☐ Frequent infections
☐☐☐ Kidney stones

**Neurological**
☐☐☐ Seizures/epilepsy
☐☐☐ Strokes
☐☐☐ Tingling sensation
☐☐☐ Numbness
☐☐☐ Muscle weakness
☐☐☐ Difficulty walking
☐☐☐ Poor coordination
☐☐☐ Paralysis
☐☐☐ Speech problems
☐☐☐ Loss of memory

**Muscle & Bone**
☐☐☐ Joint pain
☐☐☐ Swollen joints
☐☐☐ Stiffness
☐☐☐ Muscle ache
☐☐☐ Foot trouble
☐☐☐ Bone pain
☐☐☐ Fractures
☐☐☐ Dislocations

**P N B**

**Skin**
☐☐☐ Rash
☐☐☐ Itching
☐☐☐ Hives
☐☐☐ Change in moles
☐☐☐ Acne
☐☐☐ Psoriasis
☐☐☐ Eczema

**Endocrine**
☐☐☐ Diabetes
☐☐☐ Hypoglycemia
☐☐☐ Hormone therapy
☐☐☐ Thyroid problems
☐☐☐ Heat/cold intolerance
☐☐☐ Excessive thirst
☐☐☐ Excessive hunger
☐☐☐ Excessive sweating
☐☐☐ Night sweats

**Emotional**
☐☐☐ Depression
☐☐☐ Mood swings
☐☐☐ Anxiety/nervousness
☐☐☐ Tension
☐☐☐ Phobias

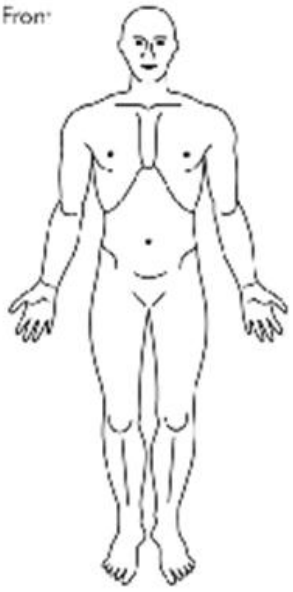
**Conditions**
☐☐☐ AIDS/HIV
☐☐☐ Eating disorders
☐☐☐ Heart disease
☐☐☐ Rheumatic fever
☐☐☐ Cancer/tumor
☐☐☐ Polio
☐☐☐ Parkinson's
☐☐☐ Multiple sclerosis
☐☐☐ Gout
☐☐☐ Anemia
☐☐☐ Osteoporosis
☐☐☐ Osteoarthritis
☐☐☐ High cholesterol
☐☐☐ Fibromyalgia
☐☐☐ Chronic fatigue
☐☐☐ Hepatitis
☐☐☐ Migraines
☐☐☐ TIAs

Using the following symbols, please indicate directly on the body diagrams below the area of your complaint and the type of pain experienced.

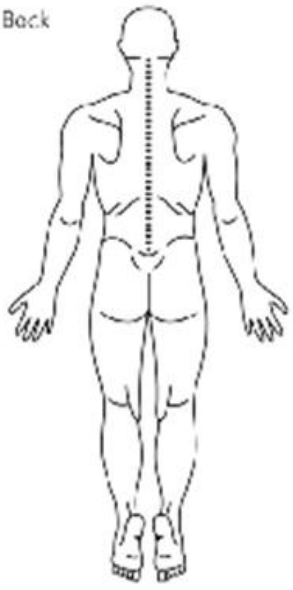
X Burning  O Dull/achy

Δ Sharp  ☐ Numbness/tingling

Front



Back



# CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

## Informed Consent to Chiropractic Treatment FORM L

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

**Dated this_____ day of_____, 20_____.**

_____ _____

**Patient Signature (Legal Guardian)** **Witness of Signature**

**Name:_____** **Name:_____**

**(please print)** **(please print)**