Date: __________ File #: ___________

ADULT CONSULTATION HISTORY

Patient Name: ________________________ Address: ____________________________

City: ____________________ Province: __________ Postal Code: ______________

Phone #(Home): ___________ (Work): ___________ Birth Date: _______________

Business Employer: ___________________ Occupation: _______________________

Email Address: __________________________________

Circle One: Married Single Widowed Divorced Separated

Number of Children: ______ Names & Ages: ________________________________

Do your children have any health problems? ___________________________________

How did you hear about our office? ____

Major concern: ____

Any other health concerns: ____

Are you taking any drugs? (Please List) _____________________________________

Have you had any major surgery or operations? (Please List) _____________________

____

Have you had any major accidents or falls? (Please Describe) ____________________

____

Have you had any previous chiropractic care? If so, please list doctor's name and date of last visit, if within the last year: ____

Who is your family doctor? ____

Do you have orthotics or wear a heel lift? ____________________

Please circle any of the following you have had in the past 6 months:

Musculo-Skeletal
Low Back Pain
Pain Between Shoulders
Neck Pain
Arm Pain
Joint Pain/Stiffness
Walking Problems
Difficult Chewing/Clicking Jaw
General Stiffness

Nervous System
Nervous
Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/Depression
Fainting
Convulsions
Cold/Tingling Extremities
Stress

General
Fatigue
Allergies
Loss of Sleep
Fever
Headaches

Gastro-Intestinal
Poor/Excessive Appetite
Excessive Thirst
Frequent Nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Liver Problems
Gall Bladder Problems
Weight Trouble
Abdominal Cramps
Gas/Bloating After Meals

Genito-Urinary
Bladder Trouble
Painful/Excessive Urination
Discoloured Urine

C-V-R
Chest Pain
Shortness of Breath
Blood Pressure Problems
Irregular Heartbeat
Heart Problems
Lung Problems/Congestion
Varicose Veins
Ankle Swelling
Stroke

EENT
Vision Problems
Dental Problems
Sore Throat
Ear Aches
Hearing Difficulty
Stuffed Nose

Male/Female
Menstrual Irregularity
Menstrual Cramps
Vaginal Pain/Infection
Breast Pain/Lumps
When was your last period? ________
Are you pregnant? Yes No Not Sure

Prostate/Sexual Dysfunction
Other Problems

____
____
____

Family History
The following have a same or similar problem as I do: Mother Father Sister Brother Spouse Child

CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of diagnostic testing, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment including, but not limited to: muscle strains and sprains, disc injuries , and strokes. For example, in specific, the risk of stroke has been documented at approximately one in one million, to one in three million. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

______________________________	______________________________
Print Patients' Name	Signature of Patient
______________________________	______________________________
Witness	Date

Dr. Heather Robson-McInnis