Temple Crossing Chiropractic & Massage
204 – 5401 Temple Drive NE

(403) 280-8992

Outline of Procedure for New Practice Members

1. STEP ONE:
All new patients are requested to fill out a personal health/history questionnaire

2. STEP TWO:
Your first consultation with the doctor to discuss your health problems.

3. STEP THREE:
Chiropractic examination and Orthopedic and Neurological examinations as related to chiropractic to determine chiropractic care for you.

4. STEP FOUR:
The doctor will advise you as to the need of additional procedures such as X-Ray tests if necessary.

5. STEP FIVE:
You will be given a "***Report of Findings***". The doctor will inform you as to your examination results. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

6. STEP SIX:
After you receive you report of findings, your recommended course of care will be explained to you.

7. STEP SEVEN:
Adjustments will begin and continue as scheduled until maximum correction for you has been obtained.

8. STEP EIGHT:
A re-evaluation to quantify your spinal health progress will be completed and you care program may be modified.

9. STEP NINE:
After maximum correction, a schedule of wellness care will be recommended.

PERSONAL HISTORY

Dear Practice Member:
Please complete this questionnaire. Your answers will help determine if Chiropractic can help you. Please answer ALL questions, even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unaware of. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name:________________________ Date:__________ Case#:______________

A.H.C. Ins. No.__________ Phone: Home________ Office________ Cell__________

Address ______________________________________ Postal Code____________

Marital Status:________ Age:______ Weight:______ Height:______ Children________

Birthdate:__________ Birthplace:__________ Occupation:________________

Employer:____________________ Family M.D.______________________

Referred to this office by: ____________ Email address:____________________

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Parent or Guardian ☐ Other__________

Insurance other than AHC? (London Life, Great West, Blue Cross, etc.) ________________

CURRENT HEALTH CONDITION

Present Complaint: ____

Have you had any previous treatment for this condition? ______________________

When did this condition begin? ___________________________________

Are there others in you family with this same condition? ______________________

Have you had any time loss from work for this condition? (If recent list dates) ______________

Is this a WCB Case? ____________ If yes-SIN and date of accident________________

Are you presently taking medication? (please mention) ________________________

When is the last time you really felt well? _____________________________

How important is your health to you on a scale of 1 – 10, 10 being the most important? __________

PAST HEALTH HISTORY

Major surgery/operations: ☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia
☐ Heart ☐ Back ☐ Neck ☐ Leg ☐ Other__________

____

Major accidents or falls: (please describe) _____________________________

____

Previous Chiropractic Care : Doctor's name and approximate date of last visit______________

Have you been treated for any health condition in the last year? ☐ Yes ☐ No

If yes, please explain ____

Check any conditions which are presently causing you a problem.
Please underline which were a problem in the past.

GENERAL

☐ headache
☐ numbness or pain in arms or legs
☐ dizziness
☐ ringing in ears
☐ whiplash
☐ fainting
☐ earache
☐ sore throat
☐ nose bleeds
☐ sinus problems
☐ asthma
☐ enlarged glands
☐ loss of weight
☐ hypoglycemia
☐ nervousness
☐ depression/confusion
☐ vision problems
☐ dental problems
☐ hearing problems

ORGANS

☐ frequent urination
☐ painful urination
☐ blood in urine
☐ bladder trouble
☐ kidney stones
☐ bed wetting
☐ prostate problems
☐ sexual dysfunction
☐ anemia
☐ thyroid
☐ excessive appetite
☐ gas/bloating
☐ nausea or vomiting
☐ constipation/diarrhea
☐ colitis
☐ black/bloody stool
☐ hemorrhoids
☐ liver trouble
☐ gall bladder trouble

SKIN

☐ eczema
☐ skin eruptions
☐ varicose veins

MUSCLE & JOINT

☐ low back problems
☐ neck problems
☐ sore joints
☐ painful tailbone
☐ pain between shoulders
☐ arthritis
☐ sore muscles
☐ walking problems
☐ broken bones
☐ difficulty chewing/ clicking jaw
☐ ankle swelling

RESPIRATORY & HEART

☐ lung problems
☐ chronic cough
☐ spit up blood
☐ frequent colds/flu
☐ shortness of breath/ difficult breathing
☐ heart problems

FEMALES ONLY

☐ painful periods
☐ irregular cycle
☐ cramps, backache
☐ vaginal discharge/infection
☐ lumps/pain in breast
☐ menopausal symptoms
☐ previous miscarriage
☐ unable to get pregnant
☐ hot flashes
☐ are you pregnant?
☐ yes ☐ no ☐ not sure
☐ when was your last period?______________

Check any of the following diseases you have had:

☐ alcoholism ☐ venereal infection ☐ epilepsy ☐ stroke ☐ arthritis ☐ hypoglycemia
☐ tuberculosis ☐ rheumatic fever ☐ diabetes ☐ cancer ☐ allergies ☐ heart disease

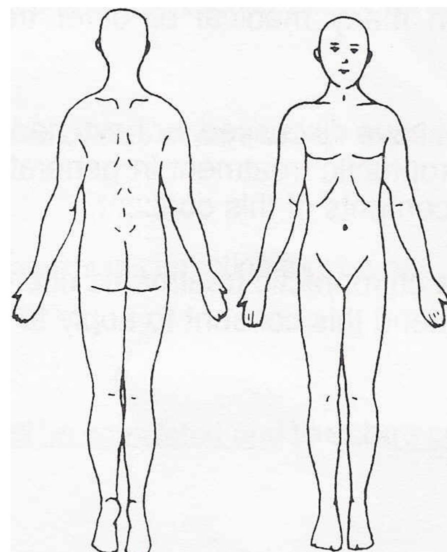
Has anyone in your family had any of the following diseases?

☐ heart disease ☐ high blood pressure ☐ cancer ☐ stroke ☐ arthritis

HABITS

	None	Light	Moderate	Heavy
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Junk Food	☐	☐	☐	☐
Stress	☐	☐	☐	☐

Please outline on the diagram the area of your discomfort.



Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (**Wellness**). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, this prepared recommendation is in incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐Relief/Initial intensive care ☐Corrective/Rehabilitative care ☐Wellness/Maintenance care

☐Check here if you want the doctor to select the type of care appropriate for your condition.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic, medical doctors, and physiotherapists who use manual therapy techniques such as spinal adjustments 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 have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
b. There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote;
c. There have been 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 multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, 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 chiropractic treatment in general and my treatment in particular (including spinal adjustments) as well as the contents of this consent.

I consent to the chiropractic treatments 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 (Legal Guardian) Witness of signature

Name: _____________________________ Name: _____________________________
(please print) (please print)