

Patient Update Card

Name: Mr Mrs Ms Miss Dr _____
(Please circle) (Last) (First) (Middle)

Mailing Address: _____ **Postal Code:** _____

Is this a new address? _____ (Y or N) **Telephone: Home** (_____) **Work** (_____) _____

Cell Phone: (_____) **Preferred Contact Number:** _____ **(Home, Cell, Work?)**

Email: _____ **(No Spam - only used to send you brief, important clinic announcements!)**

Marital Status: (S, M, D, W) _____ **Spouse's Name:** _____

Number & Ages of Children: _____

Emergency Contact Name: _____ **Telephone:** (_____) _____

Medical Doctor: _____ **Do you consent to your findings being shared with your Medical Doctor?** _____ (Y or N)

Occupation/Profession: _____ **Employer:** _____

Previous/Other Chiropractic care? _____ (Y or N) **By Whom?** _____ **When?** _____

Have you had X-rays taken? _____ (Y or N) **If yes, Date Taken:** _____ **Area/Results:** _____

Have you had a CT Scan/MRI taken? _____ (Y or N) **If yes, Date Taken:** _____ **Area/Results:** _____

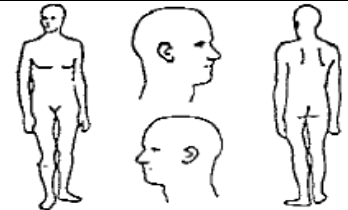
Do you have reason to believe you are pregnant? _____ (Y or N) **Due Date:** _____ **PLEASE REQUEST PREGNANCY FORM**

Are you claiming under Worker's Compensation? _____ (Y or N) **Claim Number:** _____

Are you claiming under I.C.B.C? _____ (Y or N) **Claim Number & Adjuster Name:** _____

(Y or N) Smoker? ___ If yes, how many cigarettes/packs per day? ___ Drink coffee? ___ If yes, how many cups per day? ___ Drink soft drinks? ___
 If yes, diet or regular? ___ How many cups per day? ___ Drink Tea? ___ If yes, how many cups per day? ___
 How many cups of water per day? ___ Exercise regularly? ___ Eat a balanced diet? ___ Sleep at least 8 hours a day? ___

Please briefly describe complaint(s) and mark your area of pain on the diagram on the right:



My pain/discomfort is now: 0 -----5----- 10
(indicate with an "X" on the scale) (No pain) (Worst pain)

Special Considerations: _____

Have you had any falls, accidents or injuries since your last visit? _____ (Y or N) **When?** _____

If yes, please explain _____

Have you had surgery since your last visit? _____ (Y or N) **When?** _____

If yes, please explain _____

Are you presently taking any medication? _____ (Y or N) **If yes, please give type, dosage & what it is for** _____

Informed Consent To Chiropractic Treatment

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 rather, recent studies indicate 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 and 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 Signature

Patient Name (Please print)

Witness Name (Please print)

CCPA 11/2008