Dr. Anita Chopra - Family Chiropractor
2 County Court Boulevard
Suite 400
Brampton, Ontario
L6W 3W8
Tel: 416-873-4218

Chiropractic Case History

Name____ Sex M F Date__________________________________

Address____ City____

Prov_______ Postal Code_________________ H. Phone(______)___________________ C. Phone (______)___________________

W. Phone____________________ Date of Birth__________________ Age___________

Referred by____ Emergency Contact__________________________________

Occupation____ Employer____

Single ___ Married ____ Separated ____ Widowed ____ Spouse's Name _______________________________

Have you ever received Chiropractic Care? Yes No If yes, when?_______________________________________

How did you hear about our office:_______________________ Yes, email me your monthly newsletter: ____

1. Primary reasons for seeking chiropractic care:

Primary reason: ____

Secondary reason: ____

Other factors contributing to the primary and secondary reasons: ____

2. Chief Complaint: ____

Location of Complaint: ____

Complaint Began when and how? ____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _______

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?____

Do you have any numbness or tingling in your body? Where? ____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? ____

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: ___________________

____

____

4. Past Health History:

A. Previous illnesses you've had in your life: ______________________________

____

B. Previous injury or trauma:______________________________

____

Have you ever broken any bones? Which? ______________________________

C. Allergies ______________________________

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? ______________________________

5. Family Health History:

Associated health problems of relatives: ______________________________

____

Deaths in immediate family:

Cause of parents or siblings death	Age at death

6. Social and Occupational History:

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Chiropractic Intake Form

Dr. Anita Chopra
416-873-4218
www.dranitachopra.com

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Job description: ______________________________

C. Work schedule: ______________________________

D. Recreational activities: ______________________________

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): ______________________________

Coffee ______Cups/day, Tea_______Cups/day,

7. Other

Please check any symptoms or conditions that apply to you:

- Angina/chest pain
- Heart disease
- High blood pressure
- Irregular heart rhythm
- Light headed/fainting
- Easy bleeding/bruising
- Varicose veins
- Anemia
- Cold hands/feet
- Swelling in feet/ankles
- Difficulty breathing
- Shortness of breath
- Asthma
- Bronchitis
- Anxiety/nervousness
- Depression
- Poor concentration
- Memory loss
- Vertigo/dizziness
- Seizures
- Muscle weakness
- Numbness/tingling
- Shakiness in hands
- Headaches
- Jaw pain
- Concussions
- Recurrent infections
- Hair loss
- Brittle nails
- Excess thirst
- Excess hunger
- Heat/cold intolerance
- Fatigue
- Neck pain/stiffness
- Loss of smell
- Loss of taste
- Nosebleeds
- Vision impairment/change
- Abdominal pain/cramps
- Constipation
- Diarrhea
- Black/bloody stools
- Pain with urination
- Frequent urination
- Urinary infections
- Incontinence
- Joint pain/ stiffness
- Arthritis
- Sleep problems
- Other:

Pain Diagram

Indicate all areas of

///// Stiffness

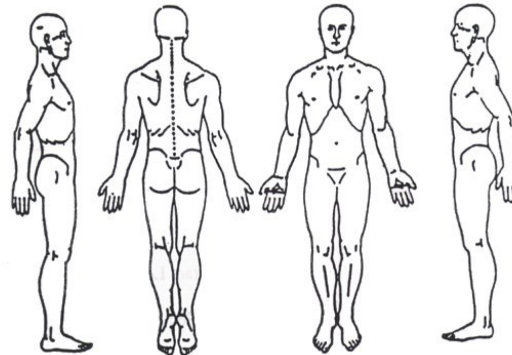
….. Numbness

0000 Pins & Needles

xxxx Burning

***** Aching

++++ Stabbing



Disclosure of Personal Information

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Dr. Anita Chopra understands the importance of protecting your personal information. The clinic will use and disclose this information as outlined below:
• to deliver save and effective patient care
• to enable us to contact you
• to communicate with your other health care providers
• to complete and submit claims on your behalf to third part payers (MVA and WSIB)
• to comply with legal and regulatory requirements under the Chiropractic Act and the Regulatory Health Professional Act
• to process payments and collect unpaid accounts

I agree and consent that Dr. Anita Chopra can collect, use and disclose my personal information as set out above in the privacy code.

______________________________________ ____________________
Signature Date

Consent

I agree and understand that I am responsible for all charges related to my visit.

______________________________________ ____________________
Signature Date

Cancellation Policy

Dr. Anita Chopra know that sometimes you cannot make your appointment. If you need to reschedule your appointment, **please call/email the clinic a minimum of 24 hours before your scheduled appointment** so that we may offer your appointment time to another patient. Failure to provide 24 hours notice or missing your scheduled appointment will result in you being charged the full visit fee.

If I am late for my appointment, I understand that my treatment time maybe not be extended as other patients maybe waiting for their appointment.

Credit Card Information

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ (MC/V/ other:____) Expiry Date: ____/____ CCV: _____

______________________________________ ____________________
Name/Signature Date

______________________________________ ____________________
Name/Witness Date

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CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

• **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

• **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

• **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

• **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

• **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

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• **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

____
Name (Please Print)

___________________________________ Date: ______________ 20____
Signature of patient (or legal guardian)

___________________________________ Date: _______________20____
Signature of Chiropractor