

**Complete Balance Health Centre**

2896 Bloor Street West  
 Toronto, ON, M8X 1B5  
 (416) 769-1163



Today's Date: \_\_\_\_\_

<b>First Name</b>				<b>Last Name</b>			
<b>Address</b>				<b>City</b>		<b>Postal Code</b>	
<b>DOB</b>				<b>Occupation</b>			
<b>H Telephone</b>		<b>Cell</b>		<b>W Telephone</b>			
<b>Email</b>							

**Physician:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**How did you hear about us?**  Friend  Internet  Signage **Other:** \_\_\_\_\_

**Name of Guardian if Applicable:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relation:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Do you have a family history of:**

Cancer	<b>YES</b>	<b>NO</b>	Heart disease/stroke	<b>YES</b>	<b>NO</b>
Diabetes	<b>YES</b>	<b>NO</b>	Allergies	<b>YES</b>	<b>NO</b>
			Other(s) _____		

**Lifestyle:**

Special Interest: \_\_\_\_\_ Sports: \_\_\_\_\_

Hobbies: \_\_\_\_\_ Health Goal: \_\_\_\_\_

Number of Hours per Week: \_\_\_\_\_

- Coffee  No  Yes \_\_\_\_\_ cups/day
- Tea  No  Yes \_\_\_\_\_ cups/day
- Cigarettes  No  Yes \_\_\_\_\_ x/day
- Alcohol  No  Yes \_\_\_\_\_ x/week
- Exercise  No  Yes \_\_\_\_\_ x/week

What type of exercise: \_\_\_\_\_

Vitamins/ Herbal Supplements?  No  Yes

What type and dosage: \_\_\_\_\_

**Mental health:**

- stress
- depression
- bipolar
- others: \_\_\_\_\_

**What level of care are you interested in pursuing?**

- symptom relief only
- preventative and maintenance care

**Have you received the following services before?**

- |  |  |
|--|--|
| <input type="checkbox"/> massage therapy | <input type="checkbox"/> psychotherapy |
| <input type="checkbox"/> naturopathy     | <input type="checkbox"/> physiotherapy |
| <input type="checkbox"/> foot care       | <input type="checkbox"/> orthotics     |

**Have you been to a chiropractor before? Yes / No If yes when?** \_\_\_\_\_

**Results: (please circle) Excellent Good Fair Poor Dr.'s Name** \_\_\_\_\_

Chiropractic Intake Form

Please indicate by circling any of the following conditions that are causing you a problem.  
Please check any conditions that have given you problems in the past.

<u>GENERAL SYMPTOMS</u>	<u>E.E.N.T Cont'd</u>	<u>RESPIRATORY:</u>	<u>M &amp; J Cont'd:</u>	<u>GASTRO Cont'd:</u>
Headache	Ear discharge	Chronic cough	Hernia	Constipation
Fever	Nose bleeds	Spitting up blood	Spinal curvature	Intestinal wounds
Chills	Nasal obstruction	Spitting up phlegm	Faulty posture	Liver trouble
Sweats	Hoarseness	Chest pain	Arthritis	Gall bladder trouble
Fainting	Sore throat	Difficulty breathing		Jaundice
Dizziness	Hay fever		<u>GENITOURINARY:</u>	Colitis
Convulsions	Asthma	<u>CARDIOVASCULAR:</u>	Frequent urination	Pain over stomach
Loss of sleep	Dental decay	rapid beating heart	Painful urination	Hemorrhoids (Piles)
Fatigue	Gum trouble	slow beating heart	Blood in urine	Bowel Movement:
Nervousness	Frequent colds	High blood pressure	Pus in urine	How often: _____
Loss of weight	Enlarged thyroid	Low blood pressure	Kidney infection	<u>FOR WOMEN ONLY:</u>
Numbness or pain in	Tonsillitis	Previous heart stroke	Kidney stones	Painful menstruation
legs, hands, arms	Sinus infection	Hardening of arteries	Bed wetting	Irregular cycle
Allergies	Nasal drainage	Swelling of ankles	Inability to control urine	Cramps or backache
Wheezing	Enlarged glands	Poor circulation	Prostate trouble	Previous miscarriage
Neuralgia		Paralytic stroke		Congested breast
<u>E.E.N.T</u>	<u>SKIN:</u>	<u>MUSCLE &amp; JOINT:</u>	<u>GASTROINTESTINAL:</u>	Lumps in breast
Failing vision	Skin eruptions	Stiff neck	Poor appetite	Menopausal symptoms
Near sightedness	Itching	Back ache	Difficult digestion	Excessive flow
Far sightedness	Bruises easily	Neck pain	Excessive hunger	Hot flashes
Crossed eyes	Dryness	Swollen joints	Belching or gas	# of pregnancies _____
Eye pain	Boils	Painful tailbone	Nausea	# of abortions _____
Deafness	Varicose veins	Foot trouble	Vomiting	# of miscarriages _____
Earache	Sensitive skin	Pain in shoulders	Vomiting of blood	
	Hives of allergy		Colon trouble	Currently pregnant? Y / N

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES? IF SO, PLEASE INDICATE:

Aneurysm	High blood pressure	Hepatitis	Polio	Sleeping difficulty
Cancer	Heart condition	Fatigue	HIV	Psoriasis
Respiratory conditions	Diabetes	Arthritis	Osteoporosis	Pneumonia

Have you ever been knocked unconscious? Yes / No. If Yes, when and how

\_\_\_\_\_

Have you been treated for your current condition before: Yes/No. If Yes, please explain

\_\_\_\_\_

Are you presently taking any medication? Yes / No. If yes please list them:

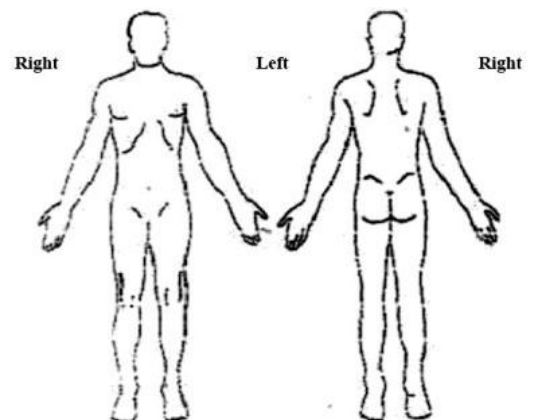
\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Pain Diagram**

Indicate all areas of

- ///// Stiffness
- Numbness
- 0000 Pins & Needles
- ××× Burning
- \*\*\*\* Aching
- ††† Stabbing



**Patient Questionnaire**

**Accidents / Falls / Fractures / Dislocations (Please describe fully starting with most recent)**

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**Have you had any surgeries? (please list starting with most recent)**

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**OVERALL HEALTH SURVEY**

1) Overall, how would you rate your health during the **past 4 weeks**?

- Excellent  Very good  Good  Fair  Poor  Very poor

2) During the **past 4 weeks**, how much did physical health problems limit your usual physical daily activities?

- none at all  A little bit  Some  Quite a lot  Could not do daily work

3) During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

- none at all  A little bit  Some  Quite a lot  Could not do daily work

4) How much bodily pain have you had during the **past 4 weeks**?

- none  very mild  mild  moderate  severe  very severe

5) During the **past 4 weeks**, how much **energy** did you have?

- Very much  Quite a lot  Some  A little  none

6) During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?

- Not at All  Very little  somewhat  quite a lot  Could not do social activities

7) During the **past 4 weeks**, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

- Not at All  slightly  moderately  quite a lot  extremely

8) During the **past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

- Not at All  Very little  somewhat  quite a lot  Could not do social activities

Score: \_\_\_\_\_



## 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: \_\_\_\_\_  
(Please print)

Name: \_\_\_\_\_  
(Please print)