new HOPE CHIROPRACTIC

PERSONAL HEALTH PROFILE

Name:

Date:

Home Address:

Town:

Postal Code:

Primary Ph:

Work Ph:

DOB: MM DD YY

Age:

Gender: ❐ M ❐ F

Who May we Thank for Referring you?

Marital Status:
❐ Single ❐ Married ❐ Divorced ❐ Widowed

Spouse's Name:

Children? Names & Age:

Have you ever received chiropractic care before? ❐ No ❐ Yes
Approx Date of Last Visit? Happy with Results? ❐ No ❐ Yes

Your Current Job:

BC Medical Card # ❐ MSP

Extended Insurance Coverage? ❐No ❐ Yes
Name:

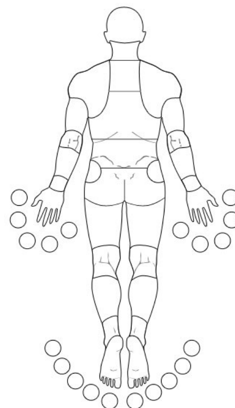
Email:

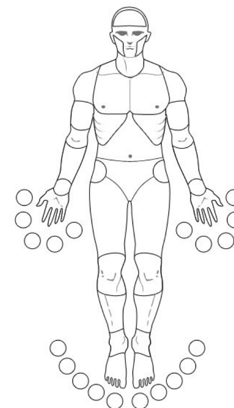
Stay up to date with New Hope events, health tips, and life giving recipes?
❐ Yes ❐ No

CHECK ANY OF THE CONDITIONS YOU CURRENTLY EXPERIENCE (*even if it doesn't relate to your problem*):

Stress Symptoms	Muscle / Joint / Bone	Neurological	Cardiorespiratory
❑ Headache/Mirgraine	❑ Backache	❑ Vertigo	❑ Asthma
❑ Dizziness	❑ Neck Pain	❑ Seizures	❑ Chest Pain
❑ Ringing in ears	❑ Tension/pain in shoulders	❑ Tremors	❑ Chronic Cough
❑ Blurred vision	❑ Arm/hand pain or tingling	❑ Numb area in the body	❑ Heart Palpitations
❑ Poor concentration	❑ Hip pain	**Ear Nose Throat**	❑ High Blood Pressure
❑ Loss of sleep	❑ Knee Pain	❑ Earache	❑ Stroke/Heart attack
❑ Depression	❑ Foot Pain or tingling	❑ Sinus Trouble	**Digestive**
❑ Decreased energy	❑ Osteoarthritis	❑ Allergies	❑ Heart Burn
❑ Irritability	❑ Scoliosis	**Females Only**	❑ Constipation
❑ Anxiety	❑ Osteoporosis	❑ Painful Menses	❑ Loose Stools
Do any family members suffer from any of these? *❐Yes ❐ No*		❑ Irregular Menses	❑ Stomach/gallbladder pain

PLEASE DRAW IN THE AREAS WHERE YOUR SYMPTOMS ARE:





New Hope Chiropractic 102-622 Hough Rd Gibsons BC V0N 1V4 604 886 9222

HISTORY OF STRESSORS

Lifestyle:	❒ Smoke? ____/ wk	❒ Alcohol? ____/ week	❒ Exercise? ____/ week	❒ Eat junk food___/wk
Habits/Stressors:	❒ Home stress	❒ Work Stress	❒ sit at work mainly	❒ Stomach sleeper
Surgeries you had:				
Medications you take	❒ Cholesterol	❒ Blood Pressure	❒ Blood Thinners	❒ Pain Killers (including Aspirin)
	❒ Insulin	❒ Stimulants	❒ Muscle Relaxants	❒ Other:________________________

Please tell us your **primary health goal** (please be specific) ____

Why do you want to be healthy?____

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect Sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturubed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restriction	Moderate pain; need to go slowly	Moderate pain; need some assisance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain	Mild pain	Moderate pain	Moderate pain	Severe pain

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/ heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain	Increased pain after 1 km	Increased pain after 1/2 km	Increased pain after 2 blocks	Increased pain with all walking

10. Standing

No Pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques 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 may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:

b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasions result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are 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 multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, 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 the chiropractic treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatment 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, and any x-rays taken at this centre.

Dated this _____ day of _____________, 20______.

____
Patient Signature (Legal Guardian)

____
Witness of Signature

____
Name (please print)

Our Fee Structure

Please note our fees for your initial visit:

Consultation:	Complimentary
Examination:	$ 35.00
Radiology:	$30.00 per film (up to $120)
Total:	up to $155.00