Red River
Chiropractic Centre

204-482-4144
357 Main St, Selkirk, MB R1A 1T5

PATIENT INTAKE

Name (legal/preferred) _____ Date of Birth (D/M/Y) _____

Address: _____

Street Number City Postal Code

Home Ph: _____Work Ph: _____ May we contact you at work? Y / N

E-mail Address: _____

Occupation _____ Employer _____

MB Prov. Health Card No. _____ PHIN (9-Digit) No. _____

Provincial Social Services _____ Workers Name _____

Extended Health Insurance: _____ RCMP/DVA ID: _____

Recent Motor Vehicle Crash (MPI) Date: _____ MPI Claim No. _____

Work Related Injury/Accident (WCB) Date: _____ WCB Claim No. _____

Number of chiropractic visits since January 1st of this year? _____

Family Doctor _____

Medications you now take: (Please Circle)

Pain Killers (analgesics) Anti-Inflammatory Muscle Relaxants Other _____

Past History

Heart (Cardiovascular) Cancer Stroke Diabetes Epilepsy Car Crashes Work Injuries Surgeries

PERSONAL HEALTH HISTORY

Headaches	Dizziness	Fever
Neck pain	Pins / Needles / Numbness in legs	Fainting / Loss of balance
Low back pain	Pins / Needles / Numbness in arms	Shortness of breath
Depression	Pain between the shoulder blades	Speech difficulty

Are you currently or regularly experiencing the following symptoms?

How were you referred to this office?

Patient Internet Phone book Co-worker Friend Family member Front sign Practitioner

HISTORY OF PRESENT INJURY

List your current injuries & rate your pain intensity (scale of 0-10 with 10 being the worst)

1) _____ ☐ 2) _____ ☐

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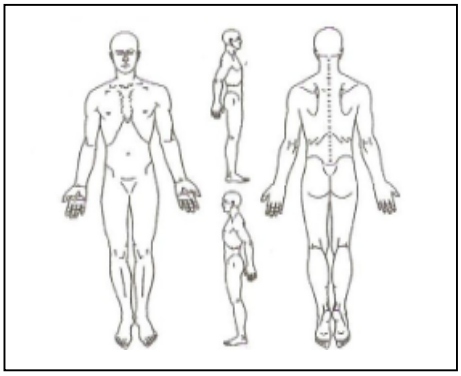
Quality of Pain

- sharp
- dull
- achy
- numb
- tingling
- shooting
- throbbing
- burning

Frequency

constant (76-100%)
frequent (51-75%)
occasional (26-50%)
intermittent (25% or less)

Mark on the picture where you have pain or symptoms



Are your symptoms? Increasing Decreasing Not Changing

What time of day are your symptoms worse? Morning Afternoon Night Same All Day

When did your problem begin? (Date if possible) _____

How did your problem begin? _____

What makes your problem **Better?** Nothing Rest Walking Standing Sitting Movement _____

When is the pain or problem **Worse?** Rest Walking Standing Sitting Movement Waking up

Do you find it difficult when? Walking Standing Sitting Bending Lifting Driving Working

Have you taken any medications for this condition? _____

Have they helped? Yes / No Somewhat

Have you been elsewhere for **This Episode**? Yes / No

If yes, where? Chiropractor M.D. Physical Therapist Massage Therapist Other _____

Did it help? Yes / No Somewhat What was the diagnosis? _____

What would you rate your general level of stress? Little or no stress Minimal Moderate Greatly

Physical activity at work? Sitting more than 50% Light labor Heavy labor Repetitive motion

General physical activity? No regular activity Light exercise program Strenuous program

Occupation _____ Fulltime / Parttime Has your work ability changed? Yes / No

What is **'Being Healthy'** to you? Not being sick Having enough energy to do what I want, when I want

Being symptom free Not needing to take time off work

To fully enjoy all aspects of life to the fullest extent possible

What statement closely represents your treatment goals and expectations?

Short Term Relief (symptoms will likely return) **Long Term Relief** (symptoms will unlikely return)

Wellness / Prevention / Maintenance Care (Pre-scheduled Adjustments, Nutritional & Exercise Strategies**)**

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic doctors are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to treatment.

There are or may be risks associated with the treatment provided by chiropractors. In particular, you should note:

a) While rare, some patients have experienced short-term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains in association with chiropractic treatment.

b) 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 treatments.

c) There are reported cases of injury to the vertebral artery and stroke in association with many common neck movements, including adjustments of the high cervical spine. The apparent association of vertebral injury and stroke with high cervical spine adjustment is noted very infrequently. Further, present medical and scientific evidence does not establish a definite cause and effect relationship between either injury to the vertebral artery or stroke and high cervical adjustment. However, you are being warned of this possible association because a vertebral artery injury or a stroke can cause serious neurological impairment, and may, on rare occasion, result on paralysis or death. The possibility of such injuries resulting from high cervical spinal adjustment is extremely remote.

Chiropractic treatment, and in particular spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other 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 the following with my chiropractic doctor: i) The condition, which the chiropractic treatment is to address; ii) The nature of chiropractic treatment; iii) The risks and benefits of that treatment; and iv) Any alternatives to treatment.

I have had the opportunity to ask questions and receive answers regarding chiropractic care.

I consent to treatments offered or recommended or offered by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Name _____ Clinic Name _____

Patient Signature _____ Clinic Signature _____

Date _____

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FINANCIAL POLICY

I understand and agree that any health/accident insurance policies are an agreement between an insurance carrier and myself ie. Manitoba Health, WCB, MPIC, RCMP, DVA, Social Assistance, and Private insurance. I understand that I am responsible for any services not paid/or not covered by my insurance. I am personally responsible for payment of all services rendered and any collection of past due accounts. If I suspend or terminate my care and treatment, fees for professional services rendered to me will be immediately due and payable.

Patient Signature _____ Date _____