ELECTRA HEALTH FLOOR

All of your therapies. Exceptional service.

WELCOME TO ELECTRA HEALTH FLOOR – CHIROPRACTIC

Name: _____

Address: _____
Street Apt/Unit # City Province Postal Code

Telephone: _____ _____ _____
Home Mobile Work

Occupation: _____ Date of Birth: _____

How did you hear about our clinic? _____

E-mail Address: _____ [For online booking and e-mail appointment reminders]

☐ I understand that Electra Health Floor uses periodic e-mails and electronic newsletters to provide appointment reminders and notify patients of changes at the clinic.

Family Physician: Dr._____ Phone #: _____

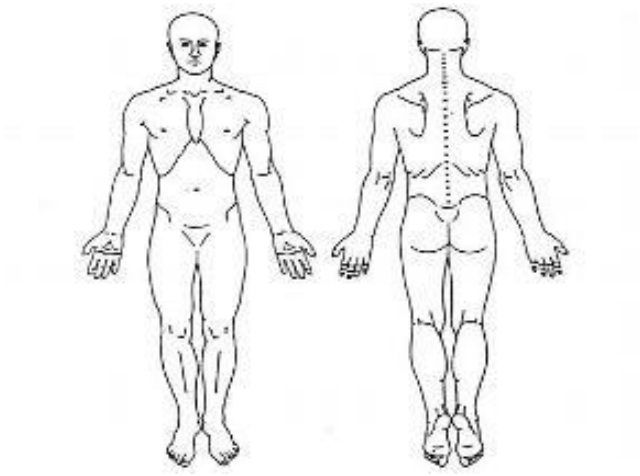
☐ I give permission to Electra Health Floor to contact my medical doctor regarding my progress with treatment, if necessary.
☐ I consent to communication between the practitioners of Electra Health Floor regarding my condition for the purpose of intra-office referral.

Are your symptoms the result of a **motor vehicle accident** or **work-related injury**? ☐ Yes ☐ No

If yes, Accident Date: _____ ICBC or WCB claim number: _____

Chief Complaint: _____

Please circle/mark the diagram below in the places that most accurately represent the pain you are experiencing:



Purpose of consulting this clinic:

☐ I am interested only in help with my current condition, i.e. relief.

☐ I am interested in help with my current condition, and in learning how to correct and prevent it in the future, i.e. corrective care.

☐ I have no current problem, but I am interested in achieving the optimum level of functioning possible through preventive care, i.e. comprehensive care.

Prior Injuries: (please circle) Fracture / Sprain / Dislocation / Head Injury / Spinal Injury / Disc Injury

***Please describe the previous injury (date, treatment received, recovery status):

_____

_____

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HEALTH STATUS SURVEY

Please ☑ for any conditions or symptoms **presently** affecting you.
Please ☒ for those conditions or symptoms that you have had **in the past**.

☐ High Blood Pressure	☐ Fainting	☐ Arthritis
☐ Low Blood Pressure	☐ Epilepsy	☐ Stroke
☐ Headache / Migraine	☐ Kidney Condition	☐ Diabetes
☐ Contagious Condition	☐ Respiratory Problems	☐ Cancer
☐ Recent Weight Loss	☐ Digestive Condition	☐ Infection
☐ Recent Weight Gain	☐ Circulatory Problems	☐ Sleep Disturbance
☐ Unexplained Fatigue	☐ Heart Condition	☐ Allergies _____

Are you currently being monitored by a health professional for a pre-existing condition?

☐ Yes ☐ No If yes, please describe: _____

Hospitalizations / Surgeries: _____

Medications (please list): _____

Supplements / Vitamins: _____

General Health: _____

Average coffee/tea consumption: _____ Average alcohol consumption: _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Stress level (please circle): Low / Moderate / High

Activity Level: Low / Moderate / High

Current activities and frequency: _____

Goal with treatment: _____

Have you received previous chiropractic care? ☐ Yes ☐ No
massage therapy? ☐ Yes ☐ No
physiotherapy? ☐ Yes ☐ No

If yes, when? _____

Cancellation Policy:

Your appointment time is reserved for you. To cancel or change an appointment, a minimum of 24 hours notice is required to avoid a late cancellation fee. Late cancellation fee for the full amount of the treatment booked will be charged.

Thank you for your cooperation. **Please initial** _____

Revised: 2016-09-01

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.

- **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