Cardio-Go THE KING WEST CLUB
266 King West · Toronto · Ontario · M5V 1H8
416 913 9123

Confidential Case History

We are pleased that you have chosen to consult us regarding your health. In order to help us evaluate your condition thoroughly, please complete the following form accurately. Please ask for assistance if needed.

Name: _____ Referred By: _____

Address: _____Apt. #: _____ City: _____ Postal Code: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

- Preferred phone number to leave messages: home ___ work___ cell___

E-mail: _____ (you will receive important info on your care to this address)

Birthdate (DDMMYY): _____ Age: _____ Gender : M F T

Occupation: _____ Name of Business: _____

Type of Work: _____ Hours Work/Study per week: _____ Computer Hours per day: _____

Medical Doctor's Name: _____MD's Address: _____

Naturopathic Doctor's Name: _____ Massage Therapist's Name: _____

Emergency Contact (name/phone #/relationship to you) _____

- May we send a thank you to the person who referred you to our office for care? Yes ___ No___

Your Health Profile

If you have no symptoms or complaints, and are here for wellness services, please check here _____, and move to section B below. Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the NEGATIVE IMPACT it has had on your QUALITY OF LIFE.

A) Reason for attending our office: _____

Location of pain? _____

Best words to describe pain? _____ How long have you had this condition? _____

Have you had this (or similar) conditions in the past? _____ Is the pain local or radiating? _____

On a scale of 1 to 10 (10 being worst pain ever felt), please rate pain: today _____ at its best _____ and at its worst _____

Pain aggravated by? _____

Pain relieved by? _____

Is condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Did this complaint start with an accident or traumatic injury YES ☐ NO ☐

How is this negatively affecting:

Your Family Life? _____ Your Career? _____

Your Social Life? _____ Your Physical Health & Recreation? _____

Your Energy/Concentration? _____ Your Sleep Quality & Quantity? _____

B) Have you had previous chiropractic care? ☐ Yes ☐ No

Where? _____ When? _____

Why? _____ Were X-Rays taken? ☐ Yes ☐ No

Other treatments tried? _____

C) How long has it been since you felt really good? _____Date of last physical _____

List any **medications** you are taking: _____

List any **supplements/vitamins** you are taking: _____

Other health problems? _____

List surgical operations (and dates): ____ _____Pregnancies? _____

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Your name:_____

As a full service health centre, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to health potential.

When in your life did you experience any of the stresses listed below: **C (child), T (teenager), A (adult), N (not at all)**

I. PHYSICAL STRESS:

					Explain
Birth Trauma (your own birth)			Yes	No	
Slips/Falls	C	T	A	N	
Sports Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying Heavy Objects	C	T	A	N	
Repetitive Lifting ___ Bending ___	C	T	A	N	
Continuous Sitting ___ Standing ___	C	T	A	N	
Bone Fracture/Surgery	C	T	A	N	
Driving For Many Hours	C	T	A	N	
Car Accidents (How many? ____)	C	T	A	N	
Physical Abuse	C	T	A	N	
Work Injuries (How many? ____)	C	T	A	N	
Stomach sleeping	C	T	A	N	(Hrs of sleep/night ____)

II. CHEMICAL STRESS:

					Explain
Smoker – Amount? (Packs per week: _____)___	C	T	A	N	
Second-Hand Smoke	C	T	A	N	
Poor Diet	C	T	A	N	(# of meals/day ____)
Caffeine – Amount? _____	C	T	A	N	
Excessive Sugar	C	T	A	N	
Artificial Sweeteners	C	T	A	N	
Prescription Drugs	C	T	A	N	
Over-The-Counter Drugs (Tylenol, Advil, etc.)	C	T	A	N	
Alcohol consumption	C	T	A	N	(# of drinks/week __)

III. EMOTIONAL STRESS:

					Explain
Relationships	C	T	A	N	
Career	C	T	A	N	
Children	C	T	A	N	
Money	C	T	A	N	
Fast-Paced Life	C	T	A	N	
Internalized Feelings	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Sickness or Loss of a Loved One	C	T	A	N	
Verbal Abuse	C	T	A	N	

IV. **WHICH DO YOU FEEL IS YOUR PRIMARY STRESS?** ☐ PHYSICAL ☐ CHEMICAL OR ☐ EMOTIONAL?

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Your name:_____

Are any of the following, current or past afflictions? (circle) Cancer -- Diabets -- Heart Disease -- Stroke -- Hypertension

Please check all symptoms you have had in the last year:

- ☐ Headaches
- ☐ Pins & needles in arms
- ☐ Pins & needles in legs
- ☐ Numbness in toes/feet
- ☐ Numbness in hands
- ☐ Sleeping problems
- ☐ Diarrhea ~~or~~ constipation
- ☐ Fatigue
- ☐ Mood swings
- ☐ Blurred vision
- ☐ Difficulty breathing
- ☐ Dizziness ~~or~~ vertigo
- ☐ Loss of smell
- ☐ Buzzing/ringing in ears
- ☐ Cold sweats
- ☐ Neck pain
- ☐ Stiff neck
- ☐ Arm pain
- ☐ Sensitive eyes
- ☐ Menstrual pain/ irregularity
- ☐ High blood pressure
- ☐ Difficulty speaking
- ☐ Fainting
- ☐ Back pain
- ☐ Loss of concentration
- ☐ Loss of taste
- ☐ Irritability
- ☐ Cold hands
- ☐ Cold feet
- ☐ Problem urinating
- ☐ Teeth grinding
- ☐ Asthma
- ☐ Sudden weakness
- ☐ Depression
- ☐ Loss of balance
- ☐ Nervousness
- ☐ Upset stomach
- ☐ Tension
- ☐ Fever
- ☐ Hot flashes
- ☐ Heartburn
- ☐ Stroke
- ☐ Sinusitis
- ☐ Difficulty walking

A) Anything else you feel we should know about:_____

_____

B) Any recent infections or illnesses? _____

C) Current exercise levels? (what and how often?) _____

Imagine you could **wish for 5 things to change about your health** in the year to come. What would they be (think big!). What would you ~~like~~ to do that you currently feel you can't do?

1. _____
2. _____
3. _____
4. _____
5. _____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Many health problems are the result of hereditary spinal weaknesses, thus, information about your family members will give us a better picture of your total health. Please mention below any health conditions or concerns you may have about your:

Children: _____
Spouse: _____
Mother: _____
Father: _____
Brother(s): _____
Sister(s): _____
Others: _____

People go to Chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to correct the underlying cause of the problem, to increase their health potential and prevent the problem from returning. Please check which type of care you are seeking:

☐ Relief Care ☐ Correction ☐ Wellness

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____
Signature Date

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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 adjustment 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 occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustments is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumber 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 multi-disciplinary 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 chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments 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.

Dated this _____day of _____, 2015.

_____ _____
Patient Name **Patient Signature (Legal Guardian)**

_____ _____
Witness Name **Witness Signature**