





## 4 Current Health Concerns

What is your reason for seeking our services? \_\_\_\_\_

What concerns do you have about your health and well being? Please list in order of importance.

**Please answer the following questions with respect to your most important concern.**

In what part of your body do you experience your pain/symptoms? \_\_\_\_\_

Does your pain/symptom travel to anywhere else in your body? Y  N

If Yes, where? \_\_\_\_\_

What does this pain/symptom feel like? Please check any that apply:

Sharp  Stabbing  Dull  Achy  Numbness  Tingling  Burning   
Cold  Pins & Needles  Electricity  Other (specify): \_\_\_\_\_

When did this pain/symptom begin? \_\_\_\_\_

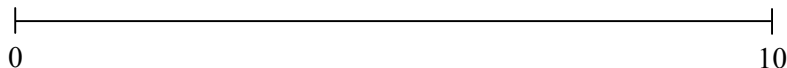
What happened? \_\_\_\_\_

How has the pain/symptom changed over time? Worse  Better  No Change

How often does this pain/symptom occur? \_\_\_\_\_

When your pain/symptom is present, how long does it last? \_\_\_\_\_

On the scale below, please mark the level of pain you most consistently feel, with 0 being no pain and 10 being the worst pain you can imagine.



What makes this pain/symptom better? \_\_\_\_\_

What makes this pain/symptom worse? \_\_\_\_\_

Are there any other related or associated concerns? \_\_\_\_\_

Have you ever experienced this pain/symptom or something similar in the past? Y  N

If Yes, please describe: \_\_\_\_\_

**Have you sought advice or treatment from a health professional?** Y  N

If Yes, what were you told? \_\_\_\_\_

What was done? \_\_\_\_\_

Did it seem to work? Y  N

Other comments/concerns?



<b>5</b>	<b>Previous Chiropractic</b>
<p>Have you been to a Chiropractor before? Y <input type="checkbox"/> N <input type="checkbox"/> If Yes, when, why did you go, what was done, what did you enjoy about your experience? _____</p> <p>_____</p> <p>Is there anything about your Nerve System and Spine that we should know about? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, describe:</p>	

<b>6</b>	<b>History of Life Stresses</b>
<p style="text-align: center;"><b>Please indicate any of these that apply to you.</b>          Show past stressors by <u>underlining</u>, show current ones by <u>circling</u>.</p>	
<b>Traumatic Events</b>	
Slips Falls Car Accidents Injury Broken Bones/Fractures Surgeries Sprains Contact Sports	
<b>Repetitive Stressors</b>	
Lifting Bending Carrying Computer work Standing/Sitting for long periods Long drives	
<b>Chemical Stressors</b>	
Smoking 2nd Hand Smoke Vaccinations OTC Drugs Recreational Drugs Alcohol Caffeine Refined Sugar Artificial Sweeteners Occupational Environmental Substance Abuse	
<b>Mental/Emotional Stressors</b>	
Relationships Family Children/Dependants Emotional/Sexual Abuse Divorce/Separation Loss of loved One Change in Residence Change in Career Work School Fast-paced Life Internalized Feelings Quick Temper Perfectionist Procrastinator Financial Illness	
<b>Birth History</b>	
Home <input type="checkbox"/> Hospital <input type="checkbox"/> Forceps <input type="checkbox"/> Caesarean Section <input type="checkbox"/>	
Other Trauma / Complications: _____	

<b>7</b>	<b>Medical History</b>
Date and reason for last visit to medical doctor (symptoms, diagnosis, treatment, outcome): _____ _____	
Please list any current medications/supplements that you are currently taking: _____ _____	
Please list any medications used in the past for more than three months and their purpose: _____ _____	
Have you or anyone in your extended biological family had any previous significant health issues? (i.e. heart disease/stroke, cancer, diabetes, infections)? Please describe: _____	



8 Wellness & Lifestyle				
How do you feel when you first wake up in the morning? How do you begin your day?	Experience of Vitality Δ Great Δ okay Δ dissatisfied			
What is the quality and quantity of your sleep and rest?	Alertness and Clarity Δ Great Δ okay Δ dissatisfied			
Yesterday, what did you choose to eat for	Level of Energy Δ Great Δ okay Δ dissatisfied			
	Ability to Fall Asleep Δ Great Δ okay Δ dissatisfied			
Breakfast? _____	Mental Focus and Concentration Δ Great Δ okay Δ dissatisfied			
Lunch? _____	Weight and Body Image Δ Great Δ okay Δ dissatisfied			
Snack? _____	Digestive Function Δ Great Δ okay Δ dissatisfied			
Dinner? _____	Bowel Movement and Urination Δ Great Δ okay Δ dissatisfied			
What is your daily fluid intake?				
How much/what physical activity do you get? Are you training?	Balance, Coordination Δ Great Δ okay Δ dissatisfied			
What type of work do you do, activities and responsibilities?	Physical Flexibility Δ Great Δ okay Δ dissatisfied			
	Physical Endurance Δ Great Δ okay Δ dissatisfied			
What do you do for play and relaxation?	Physical Strength Δ Great Δ okay Δ dissatisfied			
	Time for Self Δ Great Δ okay Δ dissatisfied			
When was your last vacation?	Work and Career Δ Great Δ okay Δ dissatisfied			
What is your future vision for yourself?	Financial Situation Δ Great Δ okay Δ dissatisfied			
What is the quality of your human relationships? Any pets?	Connectedness with Others Δ Great Δ okay Δ dissatisfied			
When stressed, how do you "centre" yourself or "re-group"?	Intimate Relationship(s) Δ Great Δ okay Δ dissatisfied			
Is there some aspect of your life that very much pleases you, brings you joy or helps you to feel good about yourself?				
On a scale of 1(low) to 10(high), please rate the following.	Resourcefulness	Current Life Stress	Level of Health	Overall Life Happiness



### What is your present motivation for consulting our office?

- Heal disease, symptoms and infirmities
- Preventing disease, symptoms and infirmities
- Improving family and/or community health
- Maximizing personal health potentials

## 9 Your Needs and Hopes for Care

In a published study of over 2,800 participants in Network Spinal Analysis, the participants reported an overall improvement in several categories of health and wellness listed below.

Please indicate how you hope to benefit from care in this office:

	Definitely	Would be Nice	Unimportant
Improvement of physical symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improvement of emotional/mental symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improvement of my ability to react/respond to stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improvement in enjoyment of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to make constructive choices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall improved quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 10 Understanding Where You're At

What is your commitment to yourself, your life and well-being on a scale of 1 to 10, where 1 is no commitment and 10 is "will do whatever it takes"? \_\_\_\_\_

Are there particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook etc. that you feel may impair your opportunity for full vitality and health? \_\_\_\_\_

Are there any factors and elements mentioned above that you feel give you an edge or add to your health? \_\_\_\_\_

Is there anything else that may help in understanding you, your history or your professional needs which have not been discussed on this survey? \_\_\_\_\_



## Consent to Chiropractic Assessment and Care at NETWORKchiropractic.ca

It is our commitment to you that you are fully informed about the services that we offer at **NETWORKchiropractic.ca** and that you understand any possible benefits or risks to the care that you receive. At **NETWORKchiropractic.ca**, the delivery of the Chiropractic Adjustment involves multiple types of force application. Type 1 consists of gentle contacts along the spine, and/or gentle body contacts and body movements. Type 2 consists of a faster, and deeper force that may or may not result in the release of a sound. Other procedures employed in this office include interviews, physical and tonal assessments, digital photo imaging, and other physiological assessment instruments.

In all healthcare professions, informed consent is required where the client is informed of benefits and risks of service. Here we agree to provide Adjustments, the client agrees to receive Adjustments, and there may be risk associated with Adjustment. There may be risk, particularly with Type 2 force applications. Possibilities include injury to muscle (strain/sprain), disc, bone, and blood vessels (stroke). To date, no valid scientific data exist which causally relate injury to vessels and the Chiropractic Adjustment<sup>1</sup>. The Chiropractic Adjustment represents less force to the vertebral artery than common activities of daily living<sup>2</sup> (ie, turning the head within normal range of motion). Available Chiropractic literature estimates a correlational value of 0.00025% (2.5 strokes/million) cervical adjustments being associated with stroke<sup>3</sup>. To put this in perspective, the risk of stroke in the general population is 0.00057% (5.7 strokes/million), which is more than double that of the Chiropractic population<sup>4</sup>. The risk of serious injury or death from taking aspirin or other anti-inflammatory drugs is 0.04% (400/million) and the risk of stroke from taking oral contraceptives is 0.004% (40/million)<sup>5</sup>. Chiropractic care is considered to be one of the safest and most effective forms of health care.

Although rare, some people experience an increase in current pain or symptoms while most do not. As the Adjustment releases more Life into the body we cannot predict what the Intelligence of the body will create. It is important to note that an increase in symptoms, although uncomfortable, may signify a positive adaptive strategy of your body.

I, \_\_\_\_\_ the undersigned have completely read and understood the above statements and consent to Chiropractic Adjustments and Procedures being performed on me by the Chiropractor and/or anyone working at **NETWORKchiropractic.ca** authorized by the Chiropractor. I have had the opportunity to discuss with the Chiropractor any questions or concerns I may have. I also understand that results are not guaranteed, and that my consent can be withdrawn or modified at any time I choose.

Signature	_____	Date	_____
Signature of parent or Guardian (for anyone under the age of 18)	_____	Date	_____
Witness	_____	Date	_____

Reference information released from:

1. Chestnut JL. *The stroke issue: paucity of valid data, plethora of unsubstantiated conjecture.* *J Manipulative Physiol Ther* 2004;27:368-72.
2. Haldeman S, Kohlbeck FJ, McGregor M. *Risk factors and precipitating neck movements causing vertebral artery dissection after cervical trauma and spinal manipulation.* *Spine* 1999;24:785-94.
3. *A Risk Assessment for cervical manipulation vs Non-steroidal anti-inflammatory drugs for the treatment of neck pain.* *J Manipulative Physiol Ther* 1995;18:530.
4. Myler, L. *Letter to Editor.* *J Manipulative Physiol Ther* 1996;19:357. Quoting from the national Center for Health Statistics.
5. Gillum, LA et al. *Ischemic stroke risk with oral contraceptives: a meta-analysis.* *J. Am. Medical Assoc.* 2000;284(1):72-78. Rothwell D, Bondy S, Williams J. *Chiropractic manipulation and stroke: a population-based case-control study.* *Stroke* 2001;32:1054-60.