northwoods
HEALTH CENTRE

Release Form For: _____

Date of Birth: _____

To: Health Records \Dr.:_____

I herby authorize and request you to release relevant reports to:

Northwood's Health Centre

Dr. Kristina Peterson D.C B.Sc.

Patient Signature: _____

1100 Roland Street Thunder Bay Ontario, P7B5M4 Ph: 807-577-3525 Fax: 807-577-3778

Email nwhc@tbaytel.net www.northwoodshealthcentre.com

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HEALTH CENTRE

CONSENT TO CHIROPRACTIC EXAMINATION&TREATMENT

It is important for you to consider the benefits, risks and alternatives to the examination procedures and treatment options offered by your chiropractic and to make an informed decision about proceeding with examination and treatment.

Chiropractic examinations can involve testing your strength, reflexes, performing various orthopedic tests as well as requiring you to move through a variety of ranges of motion. 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 headaches, 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 examinations and treatments 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 ares 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 degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may 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 damage, 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 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.

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- **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 traveling 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 towards 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, examination and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop 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 discusses 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 evaluation and treatment as proposed to me.

_____
Name (Please Print)

_____
Signature of patient (or legal guardian) Date: _____ 20_____

_____
Signature of Chiropractor Date: _____ 20_____

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PATIENT HISTORY

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Doctor of Chiropractic

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P7B5M4

Phone:
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Name: **Date of Birth:**
Last Name **First Name** **Initial** **dd/mm/yyyy**

Address: **Postal Code:**

E-mail address:

Telephone: *(Home)* *(Work)* *(Cell)*

Male □ **Female** □ **Married** □ **Single** □ **Widowed** □ **Number of Children:**_____

Health Card & Version Code _____ _____

Family Physician:_____

Date of Last Physical:_____

Past Chiropractic Care **Yes** □ **No** □ **With Whom?/When?** _____
Results: *Excellent* *Good* *Fair* *Poor*

X-rays taken **Yes** □ **No** □ **Date x-rays taken:**_____

Occupation:_____

Employer:_____ **Employer Address:**_____

Are your present problems due to injury? **Yes** □ **No** □

□ On the Job □ Auto Accident □ Personal Injury □ Other_____

Have you made a report of your injury? **Yes** □ **No** □

Do you have Extended Health Benefits through your work? **Yes** □ **No** □

Insurance Company:_____

Address:_____

Telephone:_____

*If Worker's Compensation or Insurance Claim, please complete additional form.
Inquire at front desk.

Were you referred to this office? **Yes** □ **No** □ **By Whom?**_____
(i.e., by friend, family member, doctor)

Reason for Consulting the Chiropractic Clinic: _____

_____

_____

Expectations? _____

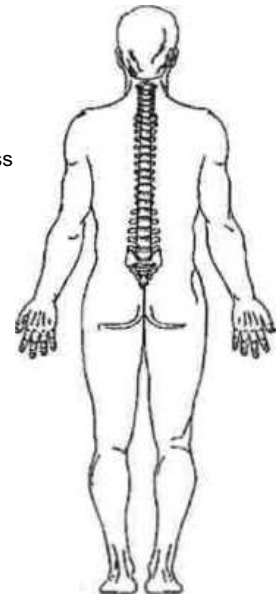
_____

_____

PATIENT HISTORY CONT.

Please mark area of pain on the drawing using these codes:

+++	Burning
000	Stabbing
~~	Sharp
III	Constant
^^^	Numbness
...	Aching

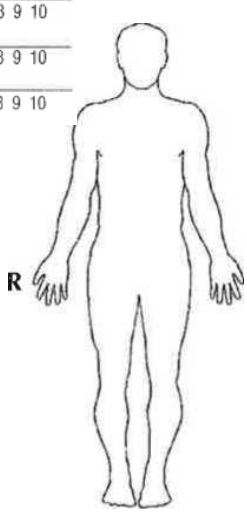


Severity of Pain
List region of pain and circle severity number.

(1 = Least, 10 = Greatest)

i.e. Neck 1 2 3 (4) 5 6 7 8 9 10

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10
4. _____ 1 2 3 4 5 6 7 8 9 10
5. _____ 1 2 3 4 5 6 7 8 9 10



What movements aggravate your condition? (i.e. bending, sitting, standing, etc)

_____

Have you had this condition before?_____

Has any other family member had this condition before?_____

What other treatment have you received for this condition?_____

List any diagnosis or treatment:_____

List any broken bones or dislocations:_____

Have you ever been hospitalized? Why?_____

List all surgeries:_____

List all falls and accidents:_____

Have you ever had a spinal injection? **Yes** □ **No** □

If so, please specify:

_____

_____

Do you suffer from any conditions other than that for which you are now consulting us? (i.e., diabetes, high blood pressure, heart problems, etc)

_____

_____

Are there any family health conditions or problems? **Yes** □ **No** □

Please List:_____

Habits

Smoking	YES☐	NO☐	How many per day?	Quit?	When?
Drinking	YES☐	NO☐	Amount per day?	Kinds?	
Coffee (Cups / day)			Tea (Cups / day)	Soft Drinks / day	

Do you take medications? **Yes** □ **No** □

Please specify:_____

Do you take Vitamins? **Yes** □ **No** □

Please specify:_____

Rate your sleep, hours per night 4-6 hours 6-8 hours 8-10 hours 10-12 hours

Do you wake up rested? **Yes** □ **No** □

PATIENT PAST HISTORY

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Please check the appropriate box for any of the following symptoms which you now have or have had previously.

C=Constant F=Frequent O=Often

C	F	O	NEUROLOGICAL
			Allergy, chills
			Convulsions
			Dizziness
			Fainting
			Fevers
			Headaches
			Loss of sleep
			Nervousness
			Depression
			Numbness
			Sweats
			Loss of weight
			Fatigue
			Frequent colds
			Asthma
			Hyperactivity

C	F	O	MUSCLE AND JOINT
			Arthritis bursitis
			Bursitis
			Foot trouble
			Hernia
			Low back pain
			Neck pain
			Neck stiffness
			Pain between shoulders
			Weakness
			Twitching
			Upper back pain
			Swollen joints
			Painful tailbone
			Spinal curvature

C	F	O	RESPIRATORY
			Chest pain
			Chronic cough
			Difficulty breathing
			Spitting blood
			Throat phlegm
			Wheezing

C	F	O	EYES, EARS, NOSE, THROAT
			colds
			crossed eyes
			deafness
			dental decay
			asthma
			ear aches
			ear discharges
			ear noises
			hearing problems
			sinus infections/problems
			enlarged glands
			enlarged thyroid
			sore throat
			tonsillitis
			eye pain
			failing vision
			far sighted
			gum trouble
			hay fever
			hoarseness
			nasal obstruction
			near sighted

C	F	O	CARDIOVASCULAR
			Rapid heart beats
			Slow heart beat
			Swelling of ankles
			Hardening of arteries
			High blood pressure
			Low blood pressure
			Pain over heart
			Poor circulation
			Strokes
			Varicose veins

C	F	O	GASTROINTESTINAL
			Excessive hunger
			Burping or gas
			Liver trouble
			Colitis
			Constipation
			Colon trouble
			Diarrhea
			Difficult digestion
			Distension of abdomen
			Stomach pain
			Gall bladder trouble
			Hemorrhoids
			Intestinal worms
			Jaundice
			Poor appetite
			Nausea
			Vomiting
			Vomit blood
			Heart burn

C	F	O	SKIN
			boils
			bruise easily
			dryness
			hives or allergy
			itching
			skin rash
			varicose veins
			eczema

C	F	O	GENITO-URINARY
			bed wetting
			blood in urine
			frequent urination
			loss urine control
			kidney infection
			painful urination
			prostate trouble
			pus in urine
			smell of urine

C	F	O	PAIN OR NUMBNESS IN
			feet
			painful tail bone
			sciatica
			swollen joints

C	F	O	PAIN OR NUMBNESS IN
			shoulders
			arms
			Hands
			hips

C	F	O	PAIN OR NUMBNESS IN
			legs
			knees

FOR WOMEN ONLY

C	F	O	
			cramps
			heavy flow
			light flow
			irregular cycle
			painful cycle
			discharge
			sore breasts
			premenstrual tension
			hot flashes
			backaches

Menopausal: **Yes** □ **No** □

Last Menstruation date:_____

Pregnant **Yes** □ **No** □

Due Date:_____

Have you ever had any of the following:

- ☐ aneurysm
- ☐ osteoporosis
- ☐ diabetes
- ☐ arthritis
- ☐ respiratory conditions
- ☐ epilepsy
- ☐ cancer
- ☐ stroke(s)
- ☐ allergies
- ☐ heart condition
- ☐ hepatitis
- ☐ nerves
- ☐ fatigue
- ☐ polio
- ☐ sleeping difficultly
- ☐ pneumonia
- ☐ pleurisy
- ☐ asthma
- ☐ VD
- ☐ psoriasis
- ☐ HIV
- ☐ sinus conditions

Please check childhood conditions:

- ☐ measles
- ☐ mumps
- ☐ chicken pox
- ☐ whooping cough
- ☐ scarlet fever
- ☐ diphtheria
- ☐ rheumatic fever
- ☐ typhoid fever
- ☐ ear infection
- ☐ tubes in ears
- ☐ chronic illness

Rate your appetite Poor Fair Medium Good Excellent

Rate your diet Poor Fair Medium Good Excellent

_____ _____

Patient Signature Date

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