

Dr. Kristina Peterson,

Doctor of Chiropractic

Doctor Of Chiropractic

Thunder Bay, Ontario

1100 Roland Street

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Fax:

# **PATIENT HISTORY**

| Name:                    |                          | Date of Birth:  |  |  |  |  |
|--------------------------|--------------------------|---|--|--|--|--|
| Last Name                | First Name               | Initial dd/mm/yyyy                                    |  |  |  |  |
| Address:                 |                          | Postal Code:  |  |  |  |  |
| E-mail address:          |                          |   |  |  |  |  |
| Telephone: (Home)        | (Work                    | k) (Cell)   |  |  |  |  |
| Male □ Female □ Ma       | arried 🗆 Single 🗆 W      | /idowed □ Number of Children:                         |  |  |  |  |
|                          |                          | Family Physician:                                     |  |  |  |  |
| Health Card & Version Co | ode                      | Date of Last Physical:                                |  |  |  |  |
|                          |                          | sarri sad 2 foat 2                                    |  |  |  |  |
| Past Chiropractic Care   | Yes □ No □               | With Whom?/When? ———————————————————————————————————— |  |  |  |  |
| X-rays taken             | Yes □ No □               | Date x-rays taken:                                    |  |  |  |  |
| Occupation:              |                          |   |  |  |  |  |
| Employer:                |                          |   |  |  |  |  |
|                          |                          |   |  |  |  |  |
| Are your present problen | ns due to injury? Ye     | es 🗆 No 🗆   |  |  |  |  |
| □ On the Job □ Auto Ac   | cident □ Personal Inju   | ry 🗆 Other  |  |  |  |  |
| Have you made a report   | of your injury?          | Yes □ No □  |  |  |  |  |
| *If Worker's Compensati  | on or Motor Vehicle ple  | ase inquire at front desk for additional forms.       |  |  |  |  |
| ·                        | ·                        | ·   |  |  |  |  |
| Do you have Extended He  | ealth Benefits through v | our work? Yes   No                                    |  |  |  |  |
| •                        |                          |   |  |  |  |  |
|                          |                          |   |  |  |  |  |
|                          |                          |   |  |  |  |  |
| reiepnone:               |                          |   |  |  |  |  |
| Were you referred to thi | is office? Yes D No      | □ By Whom?  |  |  |  |  |
| ·                        |                          | (i.e., by friend, family member, doctor)              |  |  |  |  |

| Reason for Consulting the Chiropractic                           | Clinic: Ex   | pectations?                      |                |                    |               |  |
|--|--|----------------------------------|----------------|--------------------|---------------|--|
|  | What movements aggravate                                   | your condition? (i.e. bend       | ding, sitting, | standing,          | etc)          |  |
| Please mark area of pain on the drawing using these codes:       |  |                                  |                |                    |               |  |
| +++ Burning<br>000 Stabbing                                      | Have you had this condition before?                        |                                  |                |                    |               |  |
| Sharp  | Has any other family member                                | r had this condition befor       | ·e?            |                    |               |  |
| III Constant  ^^^ Numbness  Aching                               | What other treatment have                                  | you received for this cond       | ition?         |                    |               |  |
| / ) 畫 / \  | List any diagnosis or treatme                              | nt:                              |                |                    |               |  |
|  | List any broken bones or disl                              | ocations:                        |                |                    |               |  |
| 984g   | Have you ever been hospital                                | ized? Why?                       |                |                    |               |  |
| 11/4   | List all surgeries:  |                                  |                |                    |               |  |
| ()()   | List all falls and accidents:                              |                                  |                |                    |               |  |
| Severity of Pain List region of pain and circle severity number. | Have you ever had a spinal in If so, please specify:       | njection?                        | Yes □          | No □               |               |  |
| (1 = Least, 10 = Greatest)<br>i.e. Neck<br>1 2 3(4 ) 6 7 8 9 10  |  |                                  |                |                    |               |  |
| 1. 1 2 3 4 5 6 7 8 9 10  | Do you suffer from any cond (i.e., diabetes, high blood pr |                                  | -              | ı are now          | consulting us |  |
| 2. 1 2 3 4 5 6 7 8 9 10<br>3. 1 2 3 4 5 6 7 8 9 10               |  |                                  |                |                    |               |  |
| 3. 1 2 3 4 5 6 7 8 9 10<br>4. 1 2 3 4 5 6 7 8 9 10               | Are there any family health                                | conditions or problems?          | Yes □          | No 🗆               |               |  |
| 5. 1 2 3 4 5 6 7 8 9 10  | Please List:   |                                  |                |                    |               |  |
| 11   | Habits   |                                  |                |                    |               |  |
|  | Smoking YES NO   |                                  |                |                    | When?         |  |
| -/(( ))  | Drinking YES NO Coffee (Cups / day)                        | Amount per day? Tea (Cups / day) | Kind           | 1s?<br>Drinks / da | av            |  |
| R Gul 1 hus  | Do you take medications?                                   | rea (Super day)                  | Yes □          | No □               | .,            |  |
| ) // (   | Please specify:  |                                  |                |                    |               |  |
|  | Do you take Vitamins? Please specify:                      |                                  | Yes □          | <b>No</b> □        |               |  |
|  | Rate your sleep, hours per                                 | night 4-6 hours 6-8 hou          | rs 8-10 ho     | urs 10-12          | hours         |  |
|  | Do you wake up rested?                                     |                                  | Yes □          | No □               |               |  |



# **PATIENT PAST HISTORY**

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

C=Constant F=Frequent O=Occasional

pus in urine

smell of urine

Dr. Kristina Peterson, D.C. BSc. C F O**NEUROLOGICAL** EYES, EARS, NOSE, THROAT C F O **GASTROINTESTINAL** Allergy, chills colds Excessive hunger **Dr. Shaylin Prout** Convulsions crossed eyes Burping or gas D.C. B.Sc. Dizziness deafness Liver trouble **Fainting** dental decay Colitis **Fevers** asthma Constipation 1100 Roland Street Headaches Colon trouble ear aches Thunder Bay, Ontario P7B5M4 Loss of sleep ear discharges Diarrhea Nervousness Difficult digestion ear noises **Telephone:** Depression Distension of abdomen hearing problems 807-577-3525 Fax: **Numbness** sinus infections/problems Stomach pain 807-577-3778 **Sweats** enlarged glands Gall bladder trouble Loss of weight enlarged thyroid Hemorrhoids nwhc@tbaytel.net **Fatigue** sore throat Intestinal worms www.northwoods healthcentre.com Frequent colds tonsillitis **Jaundice** Asthma Poor appetite eye pain Hyperactivity failing vision Nausea CFO**MUSCLE AND JOINT** far sighted Vomiting Arthritis bursitis gum trouble Vomit blood Bursitis hay fever Heart burn C F O Foot trouble hoarseness SKIN Hernia nasal obstruction boils bruise easily Low back pain near sighted Neck pain C F O**CARDIOVASCULAR** dryness **Neck stiffness** Rapid heart beats hives or allergy Pain between shoulders Slow heart beat itching Weakness skin rash Swelling of ankles **Twitching** Hardening of arteries varicose veins Upper back pain High blood pressure eczema Swollen joints Low blood pressure C F O **GENITO-URINARY** Painful tailbone Pain over heart bed wetting Spinal curvature Poor circulation blood in urine CFO**RESPIRATORY** Strokes frequent urination loss urine control Chest pain Varicose veins Chronic cough kidney infection Difficulty breathing painful urination Spitting blood prostate trouble

Throat phlegm

Wheezing

| scia   |   |              | sh<br>ar  | oulders<br>ms<br>ands | UMBNESS IN         | i C  | F O PAIN OR NUMBNESS IN legs knees  |
|--|---|--------------|---|-----------------------|--------------------|------|---|
| C F O  cramps heavy flow light flow irregular cramps painful cyc discharge sore breas premenstr hot flashe backaches | ycle<br>cle<br>sts<br>rual tension<br>s | L<br>P       | regnant   |                       | Yes □              | No □ |   |
| aneurysm osteoporosis diabetes arthritis respiratory co epilepsy cancer stroke(s) allergies heart conditio           | onditions                               |              | hepatitis nerves fatigue polio sleeping diffic pneumonia pleurisy asthma VD psoriasis HIV sinus condition |                       |                    |      | measles mumps chicken pox whooping cough scarlet fever diphtheria rheumatic fever typhoid fever ear infection tubes in ears chronic illness |
| Rate your appetite<br>Rate your diet   | Poor<br>Poor                            | Fair<br>Fair | Medium<br>Medium  | Good<br>Good          | Excelle<br>Excelle |      |   |
| Patient Signature  |   |              |   |                       |                    | Date |   |



# 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.

#### Ricks

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 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 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.



• 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) |           | 20 |
| Signature of Chiropractor                | <br>Date: | 20 |

