HEALTHWORKS

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3440 REGINA AVENUE, REGINA, SK S4S 7J9 P - 306-585-1824
EMAIL: webinquiry@healthworksregina.com

CHIROPRACTIC INITIAL QUESTIONNAIRE

PATIENT INFORMATION

Last Name: _____ First Name: _____

Personal Health #: _ _ _ _ _ _ _ _ _ _ Date of birth: __ __ __ __ __ __ ☐ Male ☐ Female
MM DD YY

Address: _____ City: _____ Province: _____ Postal Code: _ _ _ _ _ _

Phone #: Home: (_ _ _) _ _ _ - _ _ _ _ Work: (_ _ _) _ _ _ - _ _ _ _ Cell: (_ _ _) _ _ _ - _ _ _ _

Email: _____

Family Doctor: _____Referring Practitioner: _____

Place of Employment: _____ Occupation: _____

*NOTE: Text messaging and email are used for appointment reminders, clinic notifications and are **required** for direct billing. Do you consent to electronic communication? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____

Phone #: Home: (_ _ _) _ _ _ - _ _ _ _ Cell: (_ _ _) _ _ _ - _ _ _ _ Work: (_ _ _) _ _ _ - _ _ _ _

Will your Chiropractic treatment be covered under any of the following? Please check the appropriate box.

☐ WCB ☐ SGI ☐ RCMP ☐ DVA ☐CAF
☐ Supplementary Services (Government Program)
(Senior Income Plan, Family Income Plan and Social Services)

Claim #: _____ Contact Person: _____ Phone Number: (_ _ _) _ _ _ - _ _ _ _

Have you seen a Chiropractor before? ☐ Yes ☐ No

Dr.'s name? _____ For what complaint?_____

Have you had diagnostic imaging on the area of concern? ☐ X-ray ☐ MRI
☐ CT Scan ☐ULTRA SOUND

When? _____ Where were the images taken? _____

PAST AND CURRENT MEDICAL INFORMATION

Please **circle** any conditions that **CURRENTLY** cause you problems.
Please **check** any conditions that were a problem for you in the **past**.

General Symptoms:
Headache
Fever
Sweats
Fainting
Dizziness
Convulsions
Nervousness
Loss of weight
Numbness, pain, tingling

Genitourinary:
Poor appetite
Blood in urine
Kidney Infection
Bed wetting
Prostate trouble (men)

Respiratory:
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing

Have you recently had:
Recent fever/infection
Unexpected weight loss
Pain waking you up at night
Night sweats
Bowel or bladder problems
Numbness or tingling
History of cancer

Muscles and Joints:
Stiff neck
Backache
Swollen joints
Painful tailbone
Foot trouble
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Have you had any fractures?
_____

Cardiovascular:
Pain over heart
Stroke
Hardening of Arteries
High blood pressure
Varicose veins
Swelling of ankles
Poor circulation
Angina

G.U. for Women:
Painful menstruation
Excessive flow
Cramps or backache
Vaginal discharge
Swollen breasts
Lumps in breasts
Hot flashes
Number of pregnancies:
_____
Number of children:
_____

Do you currently have any of the following symptoms:
Dizziness
Trouble swallowing
Trouble speaking
Fainting
Double vision
Unusual balance issues
Nausea
Numbness

Gastrointestinal:
Poor appetite
Indigestion
Excessive hunger
Belching (gas)
Nausea/vomiting
Vomiting with blood
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Jaundice
Gall bladder problems
Ulcer

Eyes, Ears, Nose, Throat:
Failing vision
Crossed eyes
Eye pain
Deafness
Earache
Asthma
Frequency colds
Sinus infections
Enlarged glands
Enlarged thyroid

Skin:
Rashes
Itching
Bruises easily
Dryness
Boils

Please list past/recent surgical procedures:
_____
_____
_____
_____
_____
_____

Please list any medications you are currently taking:

_____

_____

REASON FOR VISIT

What brings you in today? _____

When did this concern begin? _____

How often does this bother you? _____ How long does it last? _____

Are there times when it does not bother you? _____

How would you describe the pain? (Sharp, stabbing, achy, dull) _____

Do you have any numbness or tingling in the arms or legs? _____

Does your pain radiate down the leg or arm? _____

Does anything relieve your symptoms? (ex: ice, heat, rest)_____

Does anything aggravating your symptoms? (ex: standing, bending over)? _____

Have you received treatment/surgery for your current complaint? If so, from whom?

Has there been a change in bowel/bladder function? ☐ No ☐ Yes Describe: _____

If the complaint is related to your back, is the pain mainly in the back or leg?

☐ Back Dominant.
☐ Leg Dominant.

Do you have a history of back problems? _____

Do you have, or have you ever had, any medical conditions? (Ex: high blood pressure, high cholesterol, diabetes, cancer, heart attack, stroke, or any other medical condition or event). Please list.

_____

Please list any past or present medical conditions that your blood-related family members are affected by. (Ex: high blood pressure, high cholesterol, diabetes, cancer, heart attack, stroke, or any other medical condition or event). Please list.

_____

Do you have any allergies? If so, please list. _____

Have you had any falls, motor vehicle accidents, or other traumatic incidents?

_____

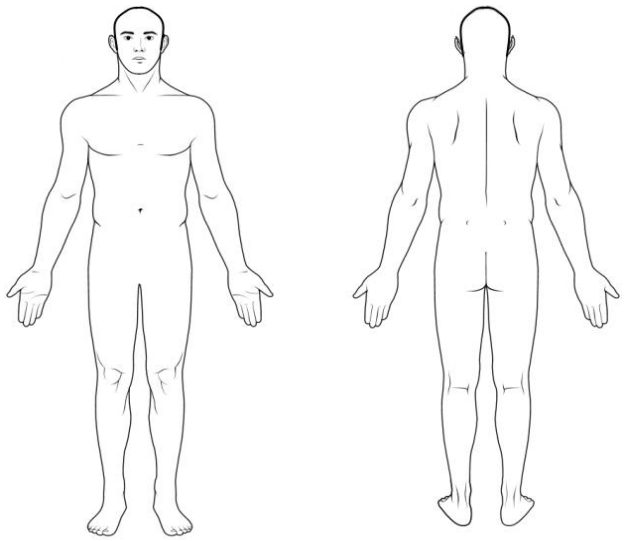
What is your height? _____ What is your weight? _____

PAIN QUESTIONNAIRES

Body Pain Diagram

Please fill this out carefully. Use the appropriate symbols to mark the area on the diagram where you feel the described sensation. Include all affected areas, including radiation of pain.

Numbness	= = =
Burning Pain	x x x
Aching Pain	(((
Pins & Needles	o o o
Stabbing Pain	/ / /



Level of Disability

What is your overall level of disability? (Please check the most appropriate response).

- ☐ No Limitations.
- ☐ Mild Limitations – able to do most activities with minor modifications.
- ☐ Moderate Limitations – able to do most activities with modifications.
- ☐ Severe Limitations – unable to perform most activities.

Visual Analog Scale

If you had to rate your pain on a scale of 0 - 10, (0 = no pain, 10 = most pain imaginable), where would you rate your pain right now? Please indicate on this scale with a check or circle.

0 1 2 3 4 5 6 7 8 9 10

HealthWorks is a multi-disciplinary clinic. If at any time you see more than one HealthWorks health care practitioner, presently or in the future, do you agree to allow your health care practitioners to communicate with each other about your case? ☐ Yes ☐ No

If the needed, do you agree to allow your HealthWorks health care practitioners to communicate with other members of your health care team outside of this office? (i.e. General Practitioner, other healthcare practitioners, medical specialists, etc…) ☐ Yes ☐ No

I hereby certify that the above information given are true and correct as to the best of my knowledge.

Patient Signature/Legal Guardian **Date**

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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