Rennicks Chiropractic Centre

Name: ____ Date:____________________

Address:____________________________________City:___________________Prov._____Postal Code:______________

Date of Birth: mm / dd / yyyy Gender: M F Marital Status: S M CL D W No. of Children:_________________

Tel. #'s: Res: ( )_________________ Bus: ( )___________________ Cell: ( )______________________

Occupation:____________________________________ e-mail:____

*Who referred you to our clinic?*____

What is your reason for seeking chiropractic care at this time?

____

Your Health Profile

Have you previously seen a Chiropractor? ☐*No* ☐*Yes When?*___________________ *Dr.'s Name:*____________________

WHY IS THIS IMPORTANT:

As a wellness based chiropractic office, we focus on your ability to be **healthy**. Our first goal is to address the issues that brought you here and secondly, to offer you the opportunity of continually improving your health and wellness. Stresses can accumulate over many years and affect your health. Answering the following questions will give us a better profile of the specific stresses you have faced in your lifetime.

Do/did you smoke? ☐*Yes*☐*No*

Did you have any surgeries? ☐*Yes*☐*No*

Any prolonged use of medications (eg. Inhalers/Antibiotics/Cholesterol)? ☐*Yes*☐*No*

Do/did you drink alcohol? ☐*Yes*☐*No*

Involved in any accidents (car/work) ☐*Yes*☐*No*

Have you fractured any bones? ☐*Yes*☐*No*

On a scale of 1 to 10, describe your level of stress (circle one).

Personal:	***(Mild)***	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	***(Severe)***
Occupational:	***(Mild)***	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	***(Severe)***

Do you exercise?_______ How often?____ days/week. What type?____

Do you take medications regularly for:

☐Heart ☐Depression ☐Diabetes ☐Pain ☐Arthritis ☐Sleep ☐Cholesterol ☐Other__________________

Name of medication(s)?____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR CLINIC

If you are experiencing pain, is it:

☐Sharp ☐Dull ☐Constant ☐Intermittent ☐Radiating ☐Other____________________________

Did it occur: ☐Suddenly ☐Gradually

How would you rate your pain on a scale of 1 to 10 (circle one)?

(Mild) 1 2 3 4 5 6 7 8 9 10 (**Severe)**

Since the problem started is it: ☐About the same ☐Getting better ☐Getting worse?
What makes it worse? ____

Does it interfere with: ☐Work ☐Sleep ☐Walking ☐Sitting ☐Hobbies ☐Leisure ☐Other___________________

Other Doctors/Therapists seen for ***this*** problem (please list):

Chiropractor:____________________________________ Medical Doctor:______________________________________

Other:___________________________________

Please check the conditions for which you have been treated:

☐Heart Disease ☐Indigestion ☐Bronchitis ☐Depression ☐Cancer ☐Dizziness ☐Stroke ☐Ulcers

☐Concussion ☐Asthma ☐Blood Pressure

Rennicks Chiropractic Centre Informed Consent

Please read carefully:

Our clinic is dedicated to helping you in recovering your health naturally. Please review the following paragraphs and sign in the area provided.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment to the Doctor. All fees are due at time of service.

In order to make a determination on the suitability of my case for chiropractic care, and to provide said care, I hereby request and consent to a thorough chiropractic assessment by the Doctor of Chiropractic indicated below and/or anyone working in this clinic authorised by the said doctor, which may include an x-ray examination if clinically indicated, chiropractic adjustments and other chiropractic procedures such as but not limited to orthotics and other orthopaedic supports. I have had the opportunity to discuss with the Doctor of Chiropractic and/or with other clinic staff, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed and I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to care, including but not limited to muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

I have read the above Consent. I have also had an opportunity to ask questions about it's content and by signing below I agree to the above mentioned chiropractic procedures. I intend this Consent Form to cover the entire course of care and I understand that I may withdraw my consent at any time.

Signature:____

Date:_______________________

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Dr. John V. Rennicks
Chiropractor