

Dr. Kelly Medeiros

Chart# \_\_\_\_\_

**PERSONAL INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Postal Code \_\_\_\_\_ Email Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ PRIMARY: Home \_\_\_ Cell \_\_\_

Preferred communication for appt. reminders (Please check one) Email \_\_\_ Phone \_\_\_

PHN (Care Card #): \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

GP Name: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Common-Law \_\_\_

Spouse's name: \_\_\_\_\_ Children's names: \_\_\_\_\_

**Pregnant: Yes \_\_\_ No \_\_\_ Due Date \_\_\_\_\_ (If Yes, Please inform the Doctor)**

Occupation: \_\_\_\_\_ City: \_\_\_\_\_ Bus #: \_\_\_\_\_

How did you hear about this office?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Other: \_\_\_\_\_

**IS THIS RELATED TO A:**

- |                                  |     |                                     |
|----------------------------------|-----|-------------------------------------|
| 1. Recent motor vehicle accident | Yes | No (if Yes, see Reception for form) |
| 2. Work related injury/accident: | Yes | No (if Yes, see Reception for form) |

**PRIOR CARE:**

Have you ever had X-rays/CT/MRI: YES NO  
(if YES) Date: \_\_\_\_\_ Area: \_\_\_\_\_  
Date: \_\_\_\_\_ Area: \_\_\_\_\_

Have you ever had Chiropractic care before: Yes No When? \_\_\_\_\_

What are you seeking? Temporary Relief Optimum Corrective Care

Name: \_\_\_\_\_

**PRIMARY CONCERNS**

Primary Complaint: \_\_\_\_\_  
\_\_\_\_\_

Date Problem began: \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Describe this concern/discomfort (aching, stabbing, numbness, etc.) \_\_\_\_\_

At this time I rate this concern at:

\_\_\_\_\_

0	1	2	3	4	5	6	7	8	9	10
No pain										Worst pain imaginable

Is this concern:    Constant    Frequent    Occasional (please circle one)

What time of the day is it worst? \_\_\_\_\_

Anything else you would like to say about this concern? \_\_\_\_\_

Any other practitioners seen for this: \_\_\_\_\_

Your expectations regarding this concern: \_\_\_\_\_

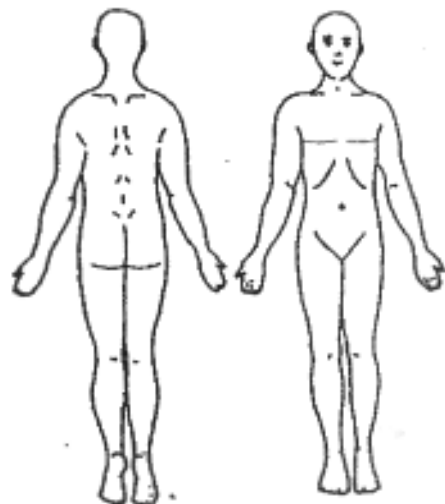
Is this concern limiting you in any way? \_\_\_\_\_

**PATIENT PRESENT SYMPTOMS**

Show area (s) of pain or unusual feeling -

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

- Numbness            .....
- Pins & Needles    000000
- Burning             XXXXX
- Aching              \*\*\*\*\*
- Stabbing            //



Name: \_\_\_\_\_

**PAST HISTORY**

Have you ever suffered from (tick all that apply)

Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No
Heart Trouble	<input type="radio"/> Yes <input type="radio"/> No	Asthma	<input type="radio"/> Yes <input type="radio"/> No
Heartburn	<input type="radio"/> Yes <input type="radio"/> No	Digestive Problems	<input type="radio"/> Yes <input type="radio"/> No
Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No	Menstrual Problems	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Depression	<input type="radio"/> Yes <input type="radio"/> No
Numbness	<input type="radio"/> Yes <input type="radio"/> No	Deafness	<input type="radio"/> Yes <input type="radio"/> No
Ear Noises	<input type="radio"/> Yes <input type="radio"/> No	High blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Bruise easily	<input type="radio"/> Yes <input type="radio"/> No	Menopausal	<input type="radio"/> Yes <input type="radio"/> No

Please list any operations with dates: \_\_\_\_\_

Please list any illnesses with dates: \_\_\_\_\_

Any other hospitalizations: \_\_\_\_\_

Please List any family health conditions (ie. Arthritis, Diabetes, Cancer, Heart disease): \_\_\_\_\_

Car Accidents (including dates and injuries): \_\_\_\_\_

Other Accidents/Falls: \_\_\_\_\_

Emotional traumas: \_\_\_\_\_

Current Medications Taken (for how long): \_\_\_\_\_

Knocked unconscious: Yes No Date: \_\_\_\_\_ For how long: \_\_\_\_\_

Rate your quality of health: Excellent Good OK Poor Terrible

List any sports, exercises, and common activities you do: \_\_\_\_\_

How many hours of sleep do you get a night? \_\_\_\_\_ Is that enough? \_\_\_\_\_

Do you follow any specific diet? \_\_\_\_\_

**CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION**

(11/08)

**Informed Consent to Chiropractic Treatment FORM-L**

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
**Patient Signature (Legal Guardian)**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Witness Name**

**\*OFFICE CANCELLATION POLICY:**

**Please note** there's a **full charge fee** for missed appointments or for those rescheduled/cancelled with less than 24 hours notice. Please remember, with less than 24 hours notice, it's difficult for others to come and fill your vacant appointment time.

**X** \_\_\_\_\_

Patient Signature acknowledging they have read and agreed to the above cancellation policy