Willoughby
FAMILY CHIROPRACTIC

#130 8700 200Street
Langley, BC V2Y 0K1
Phone: 604-371-3939 Fax 604-371-0485
www.willoughbyfamilychiro.ca

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? _____

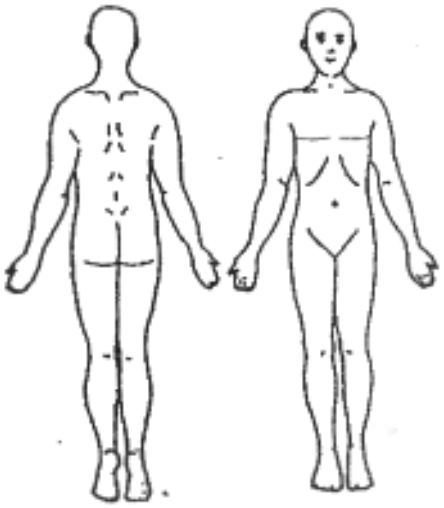
_____

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	**0000000**
Burning	**XXXXX**
Aching	*******
Stabbing	/ / / / / / /



Name:_____

PAST HSTORY

Have you ever suffered from (tick all that apply)

Dizziness	O Yes O No	Headaches	O Yes O No
Heart Trouble	O Yes O No	Asthma	O Yes O No
Heartburn	O Yes O No	Digestive Problems	O Yes O No
Sinus Trouble	O Yes O No	Menstrual Problems	O Yes O No
Cancer	O Yes O No	Depression	O Yes O No
Numbness	O Yes O No	Deafness	O Yes O No
Ear Noises	O Yes O No	High blood Pressure	O Yes O No
Bruise easily	O Yes O No	Menopausal	O Yes O 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