PATIENT HISTORY

Personal History

Today's Date:____________________

Name:________________________________Birthdate:_________________ Age:_____ Sex: ❑ M ❑ F
Address:______________________________City: ______________ Province:____ Postal Code:_________
Home Phone:__________________________Work#_____________________ Cell# ___________________
Email: ______________________________ Best way to reach you_______________Time of day_______
Business/Employer: _____________________________Type of Work: ___________________________
Health Insurance Coverage with: _________________________________
Circle One: Married Single Widowed Divorced Separated Other Number of Children:__________
Emergency Contact: ___________________ Phone Number: ____________ Relationship:_____________
Who may we thank for referring you to this office?____
How will you be paying your account? ❑ Visa ❑ Mastercard ❑ Cash ❑ Cheque ❑ Interac ❑ Other

Current Health Condition

Current Concerns/Challenges: ____
____
Other doctors seen for this condition? ❑ Yes ❑ No Who? ____________________________________
Type of Treatment: _________________________ Results:_____________________________________
When did this condition begin?________________ Has the condition occurred before? ❑ Yes ❑ No
Is the condition: ❑ Job-related ❑ Auto-related ❑ Home Injury ❑ Fall ❑ Other: _____________ ____
Date of Accident: ___________________________Time of Accident: _________________________ ____

What aggravates your condition? ❑ Sitting ❑ Standing ❑ Bending ❑ Lifting ❑ Walking
❑ Lying Down ❑ Cold ❑ Dampness ❑ Other: ____________ ____

What relieves your condition? ❑ Bed Rest ❑ Ice ❑ Heat ❑ Massage ❑ Medication
❑ Other: ____

Is it getting: ❑ Worse ❑ Constant ❑ Comes/Goes ❑ Better

Character of Pain: ❑ Sharp ❑ Dull ❑ Ache ❑ Pins & Needles ❑ Numb ❑ Burning
❑ Constant ❑ Intermittent
Please describe how it feels when this problem is at its worse: _____________________________________
On a scale of 1 to 10, rate the severity of your pain: _______

Least 1 2 3 4 5 6 7 8 9 10 *Most*

Compare this problem at its worst and a time when you feel great. How does this problem interfere with: Your ability to work? ____
Your ability to enjoy your family or your social time?____
Your ability to enjoy your hobbies or sports?____
At its worst, how old does this problem make you feel?____
If you don't get the problem corrected, do you think it will get worse over the next 5 years? ❑ Yes ❑ No
Drugs you take now: ❑ Nerve Pills ❑ Painkillers/Muscle Relaxers ❑ Blood Pressure Medicine
❑ Insulin ❑ Other: ____
Do you suffer from any other condition than the one you are now consulting us for?___________________
On a scale of 1 to 10, rate your commitment to correcting this problem: __________

Weak 1 2 3 4 5 6 7 8 9 10 *Strong*

Have you had X-rays taken in the last six months? ❑ Yes ❑ No *If yes, where?* _____________________

Name: ______________________________ **Date:**___________________________

Past Health History

Major Surgery/Operations: ❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Hernia ❑ Back Surgery
❑ Broken Bones ❑ Other: ____

Previous: ❑ Childhood Traumas ______________________ ❑ Sports Injuries____________________

❑ Motor Vehicle Accidents__________________________ ❑ Work Injuries____________________

Hospitalization (other than above):____

Previous Chiropractic Care: ❑ No ❑Yes, Doctor's name:__________________Last visit:____________

Family Health History

Name of Family Physician:____Last visit:____________

Please indicate any health issues that are present in your family:

Parents:____

Siblings:____

Does any member of your family suffer from the same condition? ❑ No ❑ Yes Whom?

Is there a family history of:

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Other__________
Father's side	❑	❑	❑	❑	❑	❑
Mother's side	❑	❑	❑	❑	❑	❑

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have had in the past six months:

Nervous System
- ❑ Nervous
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion / Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold / Tingling Extremities
- ❑ Stress

Musculo-Skeletal
- ❑ Low Back Pain
- ❑ Gas/Bloating After Meals
- ❑ Pain Between Shoulders
- ❑ Heartburn
- ❑ Neck Pain
- ❑ Black/Bloody Stool
- ❑ Arm Pain
- ❑ Colitis
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficult Chewing/Clicking Jaw
- ❑ General Stiffness

General
- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

C-V-R
- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

EENT
- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose

Gastro-Intestinal
- ❑ Poor / Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps

Male / Female
- ❑ Menstrual Irregularity
- ❑ Menstrual Cramping
- ❑ Vaginal Pain / Infections
- ❑ Breast Pain / Lumps
- ❑ Prostate / Sexual Dysfunction

Genito-Urinary
- ❑ Bladder Trouble
- ❑ Painful / Excessive Urination
- ❑ Discolored Urine

Name: ______________________________ **Date:**_________________

Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

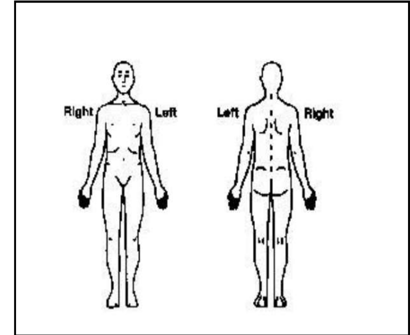
- ❑ Yes
- ❑ No

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little

Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema



Please outline on the diagram the area of your discomfort and any radiation of pain.

Female

When was your last period?_______________

Are you pregnant?

❑ Yes ❑ No ❑ Not Sure

Why Chiropractic Care? People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐ Preventative Care - Life Enhancement and Wellness Care
- ☐ Corrective Care - Removing Cause and Remodeling Soft Tissue
- ☐ Relief Care - Band-Aid Care Only
- ☐ Check here if you want the doctor to select the type of care appropriate for your condition.

Patient Signature____ Date___________________

HISTORICAL INFORMATION FOR STROKE SCREENING

Patient Name: ____Male_____ Female_____ Age_____

Have you ever been diagnosed or told you had any of the following?
(Circle the correct response) *Notes*

1. High blood pressure (hypertension)	YES	NO	
2. Hardening of the arteries (arteriosclerosis)	YES	NO	
3. Diabetes	YES	NO	
4. Heart or blood vessel diseases	YES	NO	
5. Bone spurs on the neck bones (cervical spondylosis)	YES	NO	
6. Whiplash (flexion-extension injury)(cervical sprain)	YES	NO	
7. Have you or any of your relatives ever suffered a stroke?	YES	NO	
8. Were you ever a smoker? From_______ To _______	YES	NO	
9. Are you considered to be overweight?	YES	NO	
10. High cholesterol levels	YES	NO	
11. Women Only: Have you ever taken oral contraceptives? From ______ To________	YES	NO	
12. Do you take any medication on a regular basis? List:____ (Cumidine, Heparin, Aspirin, Anti-hypertensive medicine, etc.)	YES	NO	

Have you ever experienced any of the following, even short temporary attacks?

13. Blurred vision	YES	NO
14. Double vision	YES	NO
15. Diminished or partial loss of vision in one or both eyes	YES	NO
16. Complete loss of vision in one or both eyes	YES	NO
17. Ringing, buzzing or any noise in the ear(s)	YES	NO
18. Hearing loss in one or both ears	YES	NO
19. Slurred speech or other speech problems	YES	NO
20. Difficulty swallowing	YES	NO
21. Dizziness	YES	NO
22. Temporary lack of understanding	YES	NO
23. Loss of consciousness, even momentary blackouts	YES	NO
24. Numbness or loss of sensation in the face, fingers, hands, arms, legs or other parts of your body	YES	NO
25. Any other abnormal sensations in any part of your body	YES	NO
26. Weakness, clumsiness or loss of strength in the face, fingers, hands, arms or legs	YES	NO
27. Sudden collapse without loss of consciousness	YES	NO

Patient Signature____________________________________Date____________________

IMPORTANT INFORMATION REGARDING:

MOTOR VEHICLE ACCIDENT CASES AND WORKMAN'S SAFETY AND INSURANCE BOARD CLAIMS

The Gdanski Chiropractic Clinic at 994 Oxford St., East in London, Ontario does not handle claims associated with Motor Vehicle accidents, WSIB or Personal Injury.

We do not send reports to WSIB or to lawyers.

We will refer you to another Chiropractor who is setup to accept such cases.

Please sign below.

I acknowledge the above and state that I am not making a WSIB, MVA or Personal Injury claim regarding care at 994 Oxford Chiropractic Clinic.

Print Patient Name: ____________________________

Patient Signature: ____________________________

Witnessed By: ____________________________

Date: ____________________________

Dr. Allan M. Gdanski, D.C., Chiropractic Professional Corporation, Dr. Daniel Delellis, D.C., Dr. Matthew Carstens, D.C.
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Dr. Allan M. Gdanski, D.C, Chiropractic Professional Corp. **Dr. Daniel Delellis, D.C** **Dr. Matthew Carstens, D.C.**

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