EDENVALE CHIROPRACTIC CLINIC

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Patient Intake Form

Welcome to our office of Chiropractic. Thank you for taking the time to fill in our Patient Intake Form. Please fill this form completely and th the best of your knowledge.

Patient Information

First name: _____ Last name: _____

Gender: _____ ID number: _____

Date of birth: _____

Height: _____ Weight: _____

Email: _____ Cell #: _____

Address: _____ Next of Kin: _____

_____ Number: _____

How Did you hear about us: _____ Relation: _____

Medical aid: _____ Number: _____

Main member: _____ ID number: _____

Informed Consent

Please read this consent form & sign where indicated. Chiropractors, MDs & physical therapists who use spinal manual therapies, such as joint adjustment or mobilization, are advised to inform patients that there are ormaybe some risks associated with such treatment. In Particular

a) While rare, some patients have experienced muscle soreness, ligament sprains or strains, or rib fractures following spinal adjustments

b) Some cases of temporary muscle soreness, bruising, nerve pain and pneumothorax occur following dry needling

c) There have been reported cases of injury to a vertebral artery following neck adjustment or mobilization.

Such vertebral artery injuries may on extremely rare occasion cause stroke, which may result in serious neurological injury or physical impairment. This form of complication is an extremely rare event, occurring about 1 per 5 million treatment

Treatment provided at this clinic, including spinal adjustment has been scientifically demonstrated to be appropriate and effective treatment for many common forms of spinal pain, pain in the shoulders / arms / legs, headaches, and other similar symptoms. The risk of complication or injury from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatment for the same form of musculoskeletal pain and other associated syndromes.

Your clinician will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and / or further evaluation if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician

the nature of the treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the treatment(s) offered or recommended to me by my clinician, including joint adjustment to the joints of my spine (neck and back), pelvis, and extremities (shoulder, upper limbs and lower limbs) and dry needling.

I intend this consent to apply to all my present and future treatment at this clinic.

Dated this _____ day of _____ , 20_____

_____ _____

Patients Signature Guardians Signature

Name:_____ Name:_____

(Please print name of Patient) (Please print name of Guardian)

Complaints

What is the purpose of your visit Date of injury: _____

Please describe how the injury, pain, or discomfort originated: _____

Please describe your pain or discomfort: _____

Frequency of the pain: Always Hourly Daily Occasionally

Is the pain worse at a certain time of the day: yes no

If yes please explain: _____

Agrrevating factors: yes no

If yes please explain: _____

Relieving factors: yes no

If yes please explain: _____

Previous treatment for this conditon: yes no

If yes please explain: _____

_____

Personal Health History

Family Dr: _____ Number: _____

Please list health conditions being treated: _____

Have you ever had Chiropractic care: _____ Where:_____

Are you pregnant (female only): _____

List of Medication: _____

Have you in the last 12 month (please explain):

Been Hospitalized:_____ Had surgery: _____

Had a motor car accident: _____ Had a stroke: _____

_____

Family History:

Please list health conditions in your immediate family (eg. Arthritis, cancer, diabetis, etc)

_____

_____

Social life choices: (eg. Daily, Weekly, Occasionally, Never)

Alcohol: _____ Caffiene drinks: _____

Diet products: _____ Drugs: _____

Energy products: _____ Exercise: _____

Soft drinks: _____ Tabacco: _____

Water: _____

_____

Health Problems and concerns

Please select all that you have had or currently have:

Allergies	Excessive menstruation	Poor posture
Alcoholism	Eye pain	Sciatica
Anemia	Fatigue	Shortness of breathe
Arthritis	Frequent Urination	Sinus Issues
Back Pain	Headaches	Sleep problems
Bruise easily	High blood pressure	Stroke
Cancer	Hot flushes	Swelling of ankles
chest pain	Kidney infection	Swollen joints
Cold extremities	Loss of memory	Thyroid condition
Cramps	loss of balance	TB
Depression	Loss of smell	Ulcers
Diabetes	Loss of taste	Varicose Veins
Digestive problems	Nose bleeds	Other
Dizziness	Pacemaker	_____

_____

Thank you for filling this form in

The Doctors and staff of Edenvale Chiropractic clinic