BACKS IN ACTION
WELLNESS CENTRE

#203- 1750 East 10th Avenue
Vancouver BC V5N 5K4
(604) 876-9977

Confidential Patient History Form

Today's Date:_____ **Age:**_____ **Care Card #:**_____

Name:_____ **DOB:**_____ **Shoe Size:** _____ **Weight:**_____
MM/DD/YYYY

Address:_____ **City:**_____ **Postal Code:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Email:_____ **Occupation:**_____ **Gender:** ☐ M ☐ F

We would like to keep you up to date with pertinent chiropractic and massage news, office promotions and health tips.

☐ I agree to receive commercial electronic messages (*office updates, quarterly newsletters*) from Backs in Action Wellness Centre.

☐ I agree to receive commercial electronic messages (*appointment reminders*) from Backs in Action Wellness Centre.

☐ No, I do not agree to receive commercial electronic messages from Backs in Action Wellness Centre.

Emergency Contact:_____ **Phone Number:**_____ **Relation:** _____

Physician:_____ **Phone Number:**_____

Extended Health Provider:_____ **Plan #:**_____

Plan Holder:_____ **ID #:** _____

Are you submitting a claim to ICBC/WorkSafeBC? ☐ Yes ☐ No

Claim # (specific to this injury): _____ **Adjusters Name:** _____

Date of Injury/Accident: _____ **Adjusters Phone #:** _____

Treatment you're seeking?

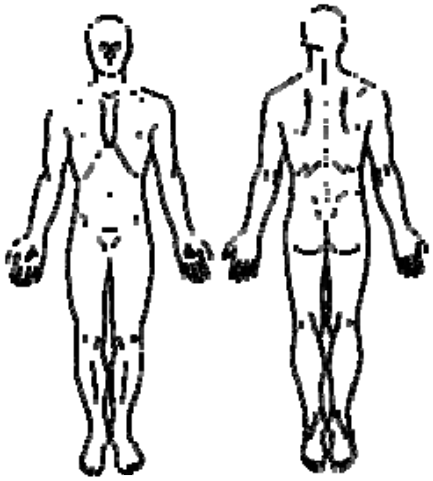
Chiropractic
Massage Therapy
Custom Orthotics
Compression Hosiery

Expectation from Treatment: _____

Describe your current condition & symptoms
(When did it start? Type of pain? Aggravating and relieving factors?)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching ○ ○ ○

Shooting → →→

Throbbing X X X

Burning # # #

Numbness ≈ ≈ ≈

Tingling Δ Δ Δ

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Have you ever been diagnosed or treated for any medical conditions? (If so, please explain):

_____

Please list all medications and/or supplements currently being taken:

_____

Please list any illnesses or conditions that run in your immediate family:

_____

Other Therapy/Treatment (within the past year):

_____

_____

Please indicate if any of the following apply to you. (P= Past, C=Current)

☐ Blood Pressure (High/Low)	☐ Stroke	☐ Myocardial Infarction	☐ Cholesterol
☐ Varicose Veins	☐ Epilepsy/Seizures	☐ Heart Attack	☐ Stroke/Aneurysm
☐ Cancer			
☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Ankylosing Spondylitis	☐ Psoriatic Arthritis
☐ Enteropathic Arthritis	☐ Diabetes	☐ Kidney Disease	☐ Liver Dysfunction
☐ Lung Disease	☐ Digestive Conditions	☐ Irritable Bowel/Colitis	☐ Bleeding Disorders
☐ Fatigue	☐ Hepatitis A/B/C	☐ Bladder Dysfunction	☐ Heartburn
☐ Asthma	☐ Sleeping Disorder	☐ Sinusitis	☐ Menopause
☐ Osteoporosis/Osteopenia	☐ Joint Sprain	☐ Recurring Muscle Strain	☐ Spinal Cord Injury
☐ Joint Dislocations	☐ Head Injuries	☐ Concussion	☐ Fracture
☐ Disc Herniations	☐ Leg Pain		
☐ Headaches			

Within the last week have you experience any of the following:

☐ Double vision ☐ Drop attacks ☐ Dizziness ☐ Dysarthria ☐ Dysphagia ___Ataxia
☐ Numbness ☐ Nausea

Please circle the answer closest to how you presently feel: (1= Poor, 5=Excellent)

Quality of Sleep 1 2 3 4 5 **Alcohol** Yes: Per week? ___ No Occasionally

Eating Habits 1 2 3 4 5 **Smoker** Yes: Length? ____ No Occasionally

Exercise Habits 1 2 3 4 5 **Number of times you exercise per week** _____

Have you had OR Do you currently own orthotics? ☐ Yes ☐ No

Please circle how you heard about our clinic?

Google Search Google Ad Website I Have A Plan Yelp Sandwich Board

Other: _____

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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.

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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.

_____ Dated: _____ day of _____ 20____
Name (Please Print)

_____ _____
Signature of patient (or legal guardian) Signature of Chiropractor

Initial that you have read the statement below ____

In Consideration of other Patients & the Practitioner, please provide 24 hours' notice if you are unable to make an appointment. For Chiropractic, any Late Cancellations or No Shows will be subject to a $30.00 Cancellation Fee. For Massage Therapy any Late Cancellations or No Shows will be subject to the full appointment fee.