Cowichan Valley Chiropractic and Wellness

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 spinal 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 demonstrated such injuries are caused, or may be caused, by spinal adjustments or other 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 of Signature
_________________________________	_______________________________
Name (Please Print)	Name (Please Print)

Cowichan Valley Chiropractic and Wellness

Patient Information and History

Date:________

1 Patient Information

Name:______________________________
(First) (Initial) (Last)
Address:____________________________
______________Postal Code__________
Birth date: mo.____ day: ____year:____
Age:______ □ Male □ Female
Employer:_________________________
Parent's name (if a minor):__________
□ Single □ Married □ Divorced
□ Widowed □ Separated
Spouse's name:_____________________
# of Children: ______

2 Insurance

BC CARE CARD#:___________________
Additional Insurer: □Yes □No
If yes: □ GreenSheild □GreatWest Life
□ Other: ___________________
Plan Member Number:
____

3 Your Contact Information

Home Phone: _____________________
Cell Phone: _______________________
Work Phone: ______________________
Email: ___________________________
Best way to reach you: □Home □Cell □Work □Email

IN CASE OF EMERGENCY, CONTACT:
Name: ___________________________
Relationship: ______________________
Home phone: _____________________
Work Phone: _____________________
Cell Phone: _______________________

4 Accident Information

Is your condition due to an accident?:
□Yes □No Date: ______________
Type of accident:
□Auto□Work□Home□Sport □Other
To whom have you reported the accident?:
□WCB□Employer□ICBC□Other
Attorney's name (if applicable):________

5

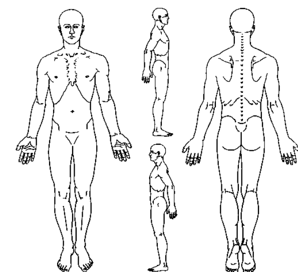
How did you hear about us?
____

May we contact your medical doctor? __
Name: ____________________________

6 Patient Condition

What is your major symptom/complaint? _______________________________________
When did your symptoms begin?: ____
Have you had this problem before?: ____
Is your condition getting worse?: □Yes □No

Please mark where it hurts



Is this problem: □Constant□Comes and goes
How does it feel?: □Burning□Sharp□Shooting□Dull□Achy
□Stiff□Tingling□Throbbing□Swelling□Other_______
Circle below the severity of your pain on a scale of 0 to 10
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
What makes your condition better?: __________________
What makes your condition worse?: __________________
Does it interfere with your □Work □Sleep □Daily Routine □Recreation
Activities/movements that are painful to perform:
□Sitting □Standing □Walking □Bending □Lying down □Driving □Reading □Getting up

Please continue on the back page...

7

Health history

What other treatments have you had for this condition?

□ Chiropractic □ Orthopedic □ Neurologist □ Physical Therapy □ Medication □ Surgery

Name of other doctors who have treated this condition:________________________

Describe the other doctors treatment for your condition:________________________

Previous Chiropractic care?: □ Yes □ No Date:____________ Local?: □ Yes □ No

Date of last: Physical exam________ X-Ray___________ MRI___________

Spinal exam_________ Dental exam:______ CT____________

List of Medications:____

List of Supplements:____

Females: Are you pregnant?: □ Yes □ No Beginning of last menstrual cycle:_____________

Check any of the following conditions which you have had:

□ Aids/HIV
□ Allergies
□ Anxiety/depression
□ Arm/shoulder pain
□ Arthritis
□ Asthma
□ Bladder problems
□ Cancer
□ Chronic fatigue
□ Deafness
□ Diabetes
□ Digestion problems
□ Earache
□ Ear ringing
□ Epilepsy
□ Headaches
□ Headaches (migraine)
□ Heart disease
□ Hemorrhoids
□ Herniated disk
□ High blood pressure
□ Insomnia
□ Irregular cycle
□ Kidney problems
□ Leg pain
□ Low back pain
□ Neck pain
□ Osteoporosis
□ Poor circulation
□ Prostate problems
□ Rheumatoid Arthritis
□ Sciatica
□ Shingles
□ Sinus Infection
□ Stroke
□ Thyroid problems
□ TMJ
□ Venereal disease
□ Vertigo/Dizziness

Stressors:

□ Smoking . . . . Packs per day:____________
□ Alcohol . . . . Drinks per week:__________
□ Coffee/Caffeine drinks . . . . . Cups per day:_____________
□ High Stress Levels . . . . Reason:__________________

Exercise:

□ None
□ Moderate
□ Daily
□ Heavy

Have you had any: **Description** **Date:**

Automobile accidents:____

Surgeries:____

Broken bones:____

Falls/head injuries:____

8

Authorization

By signing this form, I understand that I am responsible to pay for any services rendered by the Cowichan Valley Chiropractic and Wellness Clinic which I have received. Unless otherwise negotiated, all services are cash/Debit, Visa, Mastercard, or American Express only.

_______________________________ ________________ ______________________

Signature Date Guardian (if applicable)