



OKANAGAN HEALTH & PERFORMANCE

Family & Sports Chiropractic, Massage Therapy, Kinesiology & Naturopathic Medicine

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Dear Patient, welcome to **Okanagan Health & Performance**. Thank you for entrusting us with your health.

PERSONAL INFORMATION

First Name _____ Initial _____ Last Name _____ Care Card # _____
Birthdate: MM _____ DD _____ YY _____ Age _____ Gender: M _____ F _____
Address _____ City _____ Prov _____ Postal Code _____
Phone: Home _____ Work _____ Cell _____
Email _____ (for appt reminders and our newsletter)
Type of Work _____ Employer _____
Marital Status: S _____ M _____ D _____ Sep _____ W _____ Number of children _____
Emergency Contact _____ Phone Number _____
How did you hear about us? Referred by: _____ Phone book _____ Sign _____ Radio _____ Other _____

HEALTH CARE COVERAGE/CLAIM INFORMATION

Is this a work related injury/accident (WCB) or a motor vehicle related injury (ICBC)? If yes: Claim # _____
Are you claiming through the Department of Veteran Affairs (DVA, RCMP, etc)? If yes: Claim # _____
Do you have an Extended Health Plan through your Employer or Privately? If yes: Who? _____

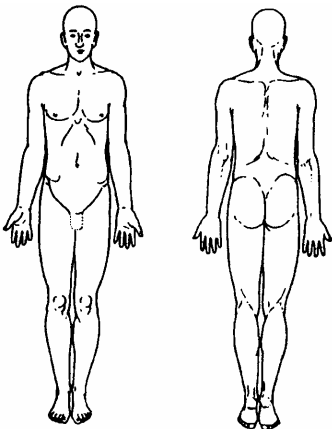
PREVIOUS CHIROPRACTIC CARE

Have you had previous chiropractic care? Y _____ N _____ Results: Excellent _____ Good _____ Fair _____ Poor _____

MEDICAL HISTORY AND INFORMATION

Your Medical Practitioner's Name: _____ Phone: _____
Date last seen _____ Reason for visit _____ Recent medical testing: Xrays _____ Blood test _____ Other _____
Permission to contact your medical doctor (Signature) _____
Are you presently taking medication/supplements? If yes, what _____

YOUR RELEVANT HISTORY FOR TODAY'S EXAMINATION



Please indicate your symptoms on the diagram using the appropriate symbol:
Aching: A Burning: B Numbness: N Stabbing: S Throbbing: T

How did your symptoms start? suddenly gradually after a fall accident lifting bending after illness woke with it other _____

When are the symptoms worse? in the morning during the day end of the day in bed during the night all the time other _____

Rate your pain (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)
Rate your disability (none) 0 1 2 3 4 5 6 7 8 9 10 (disabled)
(1 not impaired doing normal activities, 5 activities with difficulty, 10 can not function)

What makes it better? Lying down, sitting, standing, walking, movement, exercise, heat, ice, massage, medication _____

Family History; What Relation? <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Hypertension _____ <input type="checkbox"/> Arthritis _____ <input type="checkbox"/> Other _____	Your History <input type="checkbox"/> Aneurysm <input type="checkbox"/> Stroke/DVT <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart cond. <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer <input type="checkbox"/> Blood Disorder <input type="checkbox"/> High/Low BP <input type="checkbox"/> Bone Disease <input type="checkbox"/> Neurological disease	<input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> STD <input type="checkbox"/> Pregnancy <input type="checkbox"/> Arthritis <input type="checkbox"/> Other _____	Reason for visit today: <input type="checkbox"/> Pain <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Stiffness <input type="checkbox"/> General Checkup <input type="checkbox"/> Other _____
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Have you ever had ... Motor vehicle accidents, sporting accidents, personal/work accidents, fractures, surgery, dislocations?

When _____ **Give details** _____

Do you participate in a **regular exercise program, or sporting activity**? What _____ How often _____

Do you have any regular **past-times, hobbies, passions** (i.e. gardening, sewing, etc)? What _____ How often _____

Do you participate in any **health promoting activities** such as **meditation, dieting, etc**? What _____ How often _____

Do you **smoke**? If yes, how much? _____ Do you **drink alcohol**? If yes, how much? _____

Has your **body weight** changed recently? Gained ____ Lost ____ No change ____

Are you satisfied with your current fitness level? Y ____ N ____

Are there any things about yourself that you would like to change/improve? (i.e. quit smoking, lose weight, improve fitness, reduce stress, etc) Please explain _____

What is preventing you from achieving your **goals**? _____

Is there anything else that you are concerned about or would like **advice** about? _____

INFORMED CONSENT TO CHIROPRACTIC CARE (please read carefully)

Chiropractic doctors are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to treatment. There are or may be risks associated with the treatment provided by chiropractors. In particular you should note:

1. While rare, some patients have experienced short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains in association with chiropractic treatment;
2. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be cause, by spinal adjustment or chiropractic treatment.
3. There are reported cases of injury to the vertebral artery and stroke in association with many common neck movements, including adjustment of the high cervical spine. The apparent association of vertebral artery injury and stroke with high cervical spine adjustment is noted very infrequently. Further, present medical and scientific evidence does not establish a definite cause and effect relationship between either injury to the vertebral artery or stroke and high cervical spine adjustment. However, you are being warned of this possible association because a vertebral artery injury or a stroke can cause serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from high cervical spinal adjustment is extremely remote.

Chiropractic treatment, and in particular spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed the following with my chiropractic doctor:

- a. The condition which the chiropractic treatment is to address;
- b. The nature of the chiropractic treatment;
- c. The risks and benefits of that treatment; and
- d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature (Legal Guardian)
Print name: _____

Signature of witness
Print name: _____

Date