Academy Chiropractic Centre

Understanding Chiropractic Will Change Your Life!

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC! We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions, if you need assistance. We look forward to serving you.

_____

Patient Signature

_____

Today's Date

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender M F

Home Address: _____ Home Phone: ( ) _____
(as it appears on your MB Health card)

City, Province, Postal Code: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date (d/m/y): __/__/__ MB Health # 6 digit: _____ 9 digit: _____

Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name and Phone Number:

_____

How were you referred to this office?

_____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _____

Is this purpose related to an auto accident/ work injury? **YES NO** If so, when: _____

When did the condition begin? _____

Did it begin: **Gradual Sudden Progresses over time**

What activities aggravate your symptoms? _____

Is there anything which has relieved your symptoms? YES NO Describe which: _____

Type of PAIN: **SHARP DULL ACHE BURN THROB SPASM NUMB TINGLING SHOOTING**

Does the pain radiate into your: **ARM LEG Does not radiate** Is this condition getting worse? **YES NO**

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% only w/activity

Does complaint(s) interfere with: **WORK SLEEP HOBBIES DAILY ROUTINE**

Please explain: _____

Have you experienced this condition before? **YES NO** Please explain: _____

Who have you seen for this? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? **YES NO** Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before & after x-rays? **YES NO**

Did you know posture determines your health? **YES NO**

Are you aware of any poor posture habits? **YES NO** Explain: _____

Are you aware of any poor posture habits in your spouse or children? **YES NO**

The most common postural weakness id Forward Head Syndrome (head & neck start to bend forward & progressively moving downward weakening your whole body) Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or developing a "hump" at the base of your neck **YES NO**

HEALTH LIFESTYLE

Do you exercise? **YES NO** How often? **1x 2x 3x 4x 5x MORE** per week

What activities? **Running Jogging Weight Training Cycling Yoga Pilates Swimming** Other:_____

Do you smoke? **YES NO** How much? _____

Do you drink alcohol? **YES NO** How much/week? _____

Do you drink coffee **YES NO** How many cups/day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)?

_____

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose: _____

_____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called **SUBLUXATIONS** (sub-lux-a-shuns).

It has been extensively documented that subluxations, causing stress to the nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

CONSENT TO CARE

I hereby request and consent to receive chiropractic adjustments and other chiropractic procedures (if necessary) from Dr. David Newsham in this clinic. I will have an opportunity to discuss with Dr. Newsham the nature and purpose of chiropractic adjustments and care. I understand the results are not guaranteed.

I further understand and am informed that as in all health care, there are some slight risks associated with chiropractic care. Doctors of chiropractic and other health care practitioners who use spinal adjustments are required to advise their patients on the following; on rare occasions, some patients have reported rib fractures, muscle strain, ligament sprains and disc adjustments following spinal adjustments. However, no scientific study has ever verified such injuries. Spinal Adjustments are rarely associated with vertebral artery injuries. Such cases may cause stroke, sometimes with serious neurological impairment. The risk of injuries or complications to chiropractic care is substantially lower than that associated with many medical or other treatments, medications and procedures provided for symptoms like mine. I do not expect to be able to anticipate and explain all risks and complications.

During the course of my care, I wish to rely on the doctor to exercise judgment in my best interest, based upon the facts known at the time. I have read the above consent and I will have the opportunity to ask questions about its content and by signing below, I agree to the above procedures. I intend this consent to apply to all my present and future chiropractic care in this clinic.

I am aware that any personal information, past & future health history, any health issues or concerns discussed with Dr. Newsham are covered under the doctor patient privacy act. My information will not be a shared with another patient or any third party or marketing.

I consent that all the above health information is truthful to the best of my knowledge.

_____ _____

Patient Signature Witness to signature

_____ _____

Patient's Printed Name Today's Date