AURORA
MASSAGE & CHIROPRACTIC
WELLNESS CENTRE INC.

Health History Form

Name: _____ H Phone #: _____

Address: _____ C Phone#: _____

City: _____ Postal Code: _____

Birth Date: Year / Month / Day Occupation: _____

Email: _____

Would you like to receive automatic appointment reminders via email? Yes No

Emergency Contact & relationship to you: _____Phone #:_____

Family Physician & Address: _____Phone #:_____

How did you hear of us? _____

What brings you in for treatment? _____

Health History Information:

How is your overall health? _____

- Have you taken any anti-inflammatory medications, pain killers (including aspirins) muscle relaxants or mood-altering medications within the past 12 hours? If yes what and how much?

  _____

- List any stress reduction or exercise activities you do on a regular basis (including frequency):

  _____

- Please list any and all Allergies you may have

  _____

Previous History:

- Surgeries (including year and type of surgery): _____
- Accidents (including year and type of accident): _____
- Of special note (pins, wires, artificial joints/limbs etc): _____

Current Medications:

Please provide the name of the medications and what condition you are taking it for:

_____

_____

Are you currently involved with other Health Care Practitioners? **Yes/No** please indicate below

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Please indicate if any of the following conditions apply to you (past or present):

Head/Neck
- ❑ headaches
- ❑ neck pain
- ❑ whiplash
- ❑ tooth/jaw/ear pain
- ❑ vision problems/loss
- ❑ head trauma/contusions
- ❑ loss of coordination
- ❑ hearing problems

Respiratory System
- ❑ asthma/bronchitis
- ❑ chronic cough
- ❑ emphysema
- ❑ shortness of breath
- ❑ smoker
- ❑ sinus problems
- ❑ allergies/hay fever
- ❑ pneumonia
- ❑ SARS y/n date:

Muscle/Joint Pain
- ❑ neck
- ❑ low/mid/upper back
- ❑ shoulder/arms
- ❑ hip/leg/knee/ankle
- ❑ other:

Nervous System
- ❑ multiple sclerosis (MS)
- ❑ Parkinson's disease
- ❑ sciatica
- ❑ weakness/paralysis
- ❑ numbness/tingling
- ❑ herpes/shingles
- ❑ epilepsy/seizures
- ❑ loss of sensation

Skin
- ❑ open sores/cuts/wounds
- ❑ rashes/athlete's foot
- ❑ eczema/psoriasis
- ❑ bruise easily
- ❑ other:

Muscle/Joints
- ❑ muscle cramps
- ❑ sprain/strain
- ❑ tendonitis/bursitis
- ❑ limitation of movement
- ❑ work/sports injury
- ❑ fractures/bone disease
- ❑ disc degeneration/ Herniation
- ❑ osteo/rheumatoid arthritis
- ❑ scoliosis
- ❑ osteoporosis

Infectious Diseases
- ❑ tuberculosis
- ❑ HIV/AIDS
- ❑ hepatitis - type:
- ❑ infectious skin conditions
- ❑ other:

Heart/Circulation
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack/stroke
- ❑ chest pain/angina
- ❑ pacemaker
- ❑ congestive heart failure (CHF)
- ❑ edema/swelling
- ❑ dizziness
- ❑ poor circulation
- ❑ varicose veins
- ❑ phlebitis
- ❑ blood clots
- ❑ B.P: date:

Digestive System
- ❑ constipation/diarrhea/ nausea/vomiting
- ❑ heartburn/indigestion/ gas
- ❑ rapid weight loss
- ❑ appetite changes
- ❑ ulcers
- ❑ jaundice
- ❑ abdominal pain
- ❑ diverticulitis/colitis/ Crohn's
- ❑ irritable bowel syndrome (IBS)

Female
- ❑ menstrual problems – painful/heavy/scant
- ❑ pregnant?
- ❑ menopausal problems

Other
- ❑ diabetes
- ❑ thyroid disease
- ❑ sleep disturbances
- ❑ thoracic outlet syndrome
- ❑ fibromyalgia
- ❑ carpel tunnel syndrome
- ❑ hemophilia
- ❑ cancer
- ❑ other:

An accurate health history is important to ensure that it is safe for you to receive any treatment. If your health status changes in the future, please be sure to let us know. All information gathered for this treatment may be shared with other practitioners of this clinic for treatment purposes; however your information is confidential and will only be released to outside health care professionals or legal representatives upon your written consent. Please be aware that you may request to stop or alter treatment at any time for any reason and the health care professionals will comply with your wishes. **Please note that 24 hours' notice is required to cancel your appointment without charge.**

Consent: I have read and understood the above and give my consent to receive treatment.

Signature: _____ Dated: _____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

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. Recent studies suggest 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 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:_____ Name:_____

(Please print) **(Please print)**

CCPA12.08 (ENGLISH)

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WELLNESS CENTRE INC.

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent for Acupuncture Care FORM –AC

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

READ BEFORE SIGNING

_____	_____	_____
Date Signed (or parent/guardian)	**Print Patient's Name**	**Signature of Patient**

CCPA.06.03

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WELLNESS CENTRE INC.

NEW PATIENT ASSESSMENT FORM

Patient Name: _____ **Date:** _____
Age: _____
L –

O –

D –

R –

F –

I –

C –

A –

R –

A –

Relevant Secondary Complaints

\

Past DC

Past Medical

Family History

Tandem gait □ **WNL** □ **Comments:** _____

_____

Sensation □ **WNL**	**L**	**R**
Light Touch		
Sharp/Dull		
Vibration		

Reflexes □ **WNL**	**L**	**R**
Biceps (C5)		
Brachioradialis (C6)		
Triceps (C7)		
Patellar (L4)		
Achilles (S1)		
Plantar Reflex		

Motor □ **WNL**	**L**	**R**
Shoulder ABD (C5)		
Wrist EXT (C6)		
Wrist FLEX (C7)		
Finger FLEX (C8)		
Finger ABD/ADD (T1)		
Ankle Inversion (L4)		
Ankle Dorsiflexion (L5)		
Ankle Plantarflexion (S1)		
Ankle Eversion (S1)		

RANGE OF MOTION

ACTIVE

PASSIVE

RESISTED

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