acacia health
health, through science & nature

Chiropractic Health History Form

General Information:

Name___________________________________ Birthdate _______________________ Date________________
MSP #________________ Address____ City_____________
Prov/State_____________ Postal Code__________________ Phone (home) ___________________
Phone (work) __________Best time to call __________________ Can we leave messages for you here? Y N
Email ____________________________ Occupation_____________________________________
Emergency contact _________________________ Relation? _________________ Phone______________________
Is this a WCB or ICBC Claim? Yes /No If yes, please include the following information:
Claim #___________________
Name of Adjuster: ____________________________________ Date of Injury: ______________________________
How did you hear about us? ____
Have you consulted any other health care professionals about this complaint? If yes, who did you see, when did you see them, were you given a diagnosis? ____
____
____

Your lifestyle:

What do you do for FUN? (Hobbies /Recreation) ____
____

How many hours of SLEEP do you average per night?

Less than 5 hours

- 6-8 hours
- 9+ hours

Do you typically wake up feeling rested?

- Yes
- No

How do you typically sleep?

- On Side
- On Stomach
- On Back
- All of the Above

How many hours per day do you spend looking at a SCREEN/MONITOR?

- 0-2
- 2-5
- 5-8
- 8+

Do you smoke or use TOBACCO? If yes, please provide how often and for how many years. ____________________
Do you drink ALCOHOL? If yes, please provide how many drinks you have on average per week. ________________
Do you currently or regularly use any of the following? Mark all that apply.

- Coffee
- Black or Green Tea
- Soft Drinks
- Laxatives
- Pain Medication
- Marijuana
- Other Recreations Drugs/ Intoxicants

Please rate your level of **PHYSICAL ACTIVITY**

1	2	3	4	5
None	Mild	Moderate	High	Extreme

Please rate your level of **STRESS**

1	2	3	4	5
None	Mild	Moderate	High	Extreme

Please rate your level of NUTRITION
- Poor (I eat a lot of processed foods)
- Could Improve (I typically don't eat well/ rarely prepare my own food)
- Good (I typically eat well/ cook/ prepare most of my own food)
- Excellent (I have a healthy diet/ take supplements to optimize my nutrition)

Please rate your level of HYDRATION
- Poor (rarely or never drink water)
- Could Improve (could drink more water)
- Good (I drink enough water)
- Excellent (I only drink water)

Current Health Concerns:

Have you ever received chiropractic care before? If yes, please provide approximate date of your last appointment.
- Yes____
- No____

What is the reason for seeking care?
- Symptomatic Relief
- Corrective Care
- Both Symptomatic & Corrective Care
- Improve or Maintain Spinal Health

MOI (Mechanism of Injury)- How did the complaint begin? ____

____

____

Chief Complaint- Please describe your primary area of complaint. ____

____

____

Onset Complaint- Please describe your primary area of complaint. ____

____

____

Symptoms:

How frequent are your symptoms?
- Constant
- Frequent
- Intermittent
- Occasional
- Rare

Are your symptoms predictably worse at certain points during the day?

- Worse in the Morning
- Worse in the Evening
- Worse when I'm trying to sleep
- Consistent throughout the day
- Random

Have you experienced the same (or similar) symptoms in the past? If yes, please briefly describe how often these symptoms return and how long they typically last.

- Yes____
- No____

Have you noticed any change to your symptoms since they first presented/last returned?

- Unchanged
- Slight Improvement
- Moderate to Significant Improvement
- Slight Worsening
- Moderate to Significant Worsening

Quality of Pain- Mark all that apply

- Stiff/ Tight
- Achy
- Dull
- Deep
- Sharp
- Burning
- Throbbing
- Shooting
- Other____

Pain Levels & Information:

Please circle the following:

Current Pain Level (0=None, 10=Most Possible Pain)

____

1 2 3 4 5 6 7 8 9 10

Average Pain Level (over the last 7 days) (0=None, 10=Most Possible Pain)

____

1 2 3 4 5 6 7 8 9 10

Worst Pain Level (over the last 7 days) (0=None, 10= Most Possible Pain)

____

1 2 3 4 5 6 7 8 9 10

Relieving Factors- What improves your symptoms? ____
____
____

Aggravating Factors- What worsens your symptoms? ____
____
____

Are you experiencing any Numbness, Tingling or Weakness? If so, where?

- Numbness____
- Tingling____
- Weakness____

Have you noticed any signs of inflammation around your area of complaint? -Mark all that apply

- Bruising
- Redness
- Swelling
- Deformity
- Increased Heat
- N/A

Have you experienced any recent signs of illness? Mark all that apply

- Headache
- Nausea
- Dizziness
- Visual Disturbances
- Confusion /Fogginess
- Fainting
- Trouble Speaking
- Trouble Chewing/ Swallowing
- Hearing Loss
- Shortness of Breath
- Pain with Coughing, Sneezing, or Bearing Down
- Pain or Issues with Bowel or Bladder Function
- Other

Do you have any secondary areas of complaint? ____
____
____

Your Health History:

Have YOU or any IMMEDIATE FAMILY members been diagnosed with any of the following?

- Cancer
- Heart Disease
- Stroke
- High Blood Pressure
- Diabetes
- Lupus
- Rheumatoid Arthritis
- Connective Tissue Disorders (Ehlers Danlos, Marfan Syndrome)
- Others

If you have checked ANY of the above boxes, please specify who has/had the condition. _______________________

Have you ever been in a MOTOR VEHICLE ACCIDENT? If yes, please briefly describe what happened. ________
____
____
____

Do you have any previous history of TRAUMA/INJURY to (or around) your area of complaint? _______________
____
____

Please list any current or recent use of MEDICATIONS or SUPPLEMENTS and the reason for taking them. ______
____
____

Do you have any known ALLERGIES? ____
____

Please list any SURGERIES you have had performed (including recent dental surgeries). ______________________
____
____

Have you had any IMAGING taken of your area of complaint? If yes, when were they taken?

- X-Ray ____
- CT Scan ____
- MRI ____
- Ultrasound ____
- Other ____

Is there anything else you would like the Doctor to know? ____
____
____

Acacia Health Clinic
Suite #130-180 Wilson St, Victoria, B.C., V9A 7N6
Tel: 250-475-1522 Fax: 250-590-6430
www.acaciahealth.ca

Acacia Confidentiality Agreement and Informed Consent *for Chiropractic Patients*

A Chiropractor is a doctor of manual medicine who focuses on the assessment, diagnosis and treatment of the tissues, joints and nerves of the body. Chiropractors are best known as spinal experts but also commonly treat muscle, headache, TMJ and extremity problems. At Acacia we use soft tissue therapy, rehabilitative exercise, joint manipulation, patient education and appropriate referrals to tailor a treatment plan that works best for each patient's needs.

I understand that I must inform my Chiropractor immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant or suspect I may be pregnant.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the Chiropractors at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that fees are payable at the time of appointment.

I understand that 24 hours' notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee.

I understand that the results are not guaranteed. I do not expect the Chiropractor will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the therapeutic procedures mentioned above. I intend this consent form to cover the entire course of treatment with any/all Acacia Chiropractors. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

___________________________	___________________________
Patient Name (Please Print)	Name of guardian if patient is a child
___________________________	___________________________
Signature of Patient (or Guardian)	Today's Date

☐ *Optional Consent (please initial box)*: I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.
Chiropractor Signature: ____

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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.

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.

____

Name (Please Print)

_____________________________________ Date: ____________________

Signature of patient (or legal guardian)

_____________________________________ Date: ____________________

Signature of Chiropractor