Total Body Health Welcomes You!

Name: _____

Date of birth:_____M____F ____Marital Status _____No. Of children _____

Mailing address:_____Postal Code:_____

Home Phone:_____Work Phone:_____ Cell Phone #: _____

Email Address:_____ Check this box to be added to our Newsletter □

CareCard Health #: _____

Employer: _____Occupation: _____

Referred by: _____

Is this related to: ICBC _____WCB_____DVA____Claim number: _____

In case of emergency, please list the name/number of a friend or relative:_____

HABITS, DRUGS, and VITAMINS (describe with amounts):

Sleep: Arise:_____Retire: _____Vacations:_____ Exercise:_____

Alcohol_____ Coffee/Tea_____ Cigarettes_____

Diet_____ Are you taking any nutritional supplements? _____

Are you currently taking any medication?_____ Describe:_____

_____

What is your reason for consulting the doctor? _____

_____ How long have you had this condition?_____

What important activity have you been unable to do because of your condition? _____

Have you had this or similar conditions in the past? _____

Is this problem getting worse? _____ Constant? _____ Worse in the morning? ____ Evening? _____

Is this interfering with work? _____ Sleep? _____ Exercise?_____ Other?_____

Have you seen other chiropractors/doctors for this condition?_____

Are there any other problems that you are currently experiencing?_____

_____

Date of your last physical exam? _____ Dr.:_____

Have you ever been hospitalized? _____

Are you allergic to any foods, drugs, chemicals etc.? _____

Remarks and any additional information:_____

Do you use birth control?_____ When was the date of your last period?_____

Please circle the appropriate letter for any of the following symptoms which you now have or have had previously.

C = Constant F = Frequent O = Occasional

NEUROLOGICAL

C F O numbness
C F O allergy
C F O dizziness
C F O dropping things
C F O double vision
C F O fainting
C F O fevers
C F O headaches
C F O loss of sleep
C F O weight loss
C F O weight gain
C F O nausea
C F O neuralgia
C F O sweats
C F O tremors
C F O co-ordination off

MUSCLE AND JOINT

C F O arthritis
C F O bursitis
C F O low back pain
C F O pain btw shoulders
C F O neck pain
C F O neck stiffness
C F O sciatica

RESPIRATORY

C F O chest pain
C F O chronic cough
C F O difficulty breathing
C F O spitting blood
C F O throat phlegm
C F O wheezing
C F O asthma

EYES, EARS, NOSE, & THROAT

C F O colds
C F O deafness
C F O dental problems
C F O ear aches
C F O ear noises
C F O sinus infections
C F O enlarged glands
C F O sore throat
C F O tonsilitis
C F O eye pain
C F O failing vision
C F O gum trouble
C F O hay fever
C F O hoarseness
C F O nasal obstruction
C F O nose bleeds

CARDIO-VASCULAR

C F O rapid heart beat
C F O slow heart beat
C F O swelling of ankles
C F O hardening of arteries
C F O high blood pressure
C F O low blood pressure
C F O pain over heart
C F O poor circulation

SKIN

C F O bruise easily
C F O dryness
C F O hives or allergy
C F O itching
C F O skin rash
C F O varicose veins

GASTROINTESTINAL

C F O excessive hunger
C F O burping or gas
C F O liver trouble
C F O colon trouble
C F O constipation
C F O diarrhea
C F O difficult digestion
C F O abdomen distended
C F O stomach pain
C F O gall bladder trouble
C F O hemorrhoids
C F O poor appetite
C F O nausea
C F O vomiting

GENITO-URINARY

C F O blood in urine
C F O frequent urination
C F O kidney infection
C F O painful urination
C F O prostrate trouble
C F O smell of urine

FOR WOMEN ONLY

C F O cramps
C F O heavy flow
C F O light flow
C F O irregular cycle
C F O painful cycle
C F O discharge
C F O sore breasts

Menopausal: Yes No

Last menstruation date:

_____

Pregnant: Yes No

HISTORY:

Previous Surgeries (When and where on your body):

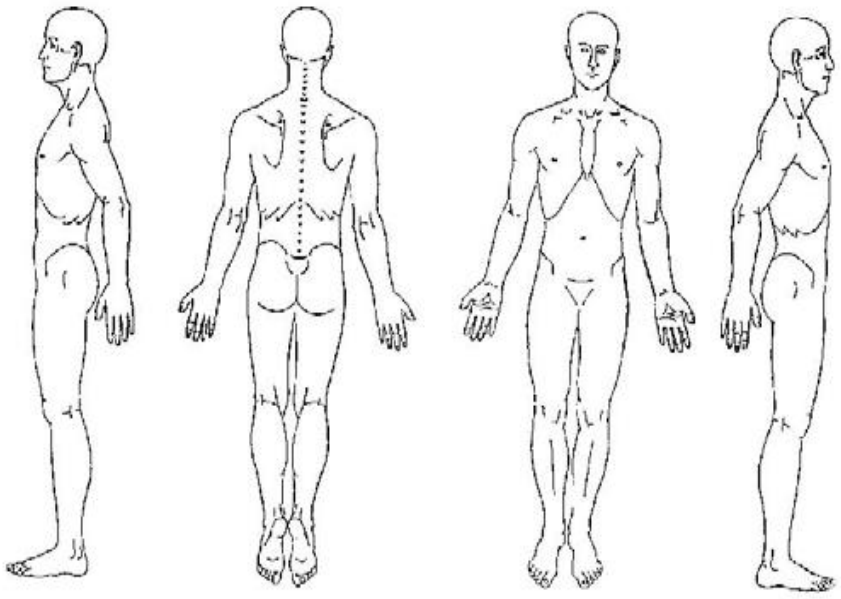
Car Accidents (When and Briefly describe):

Falls, Tumbles, Concussions, Broken Bones:

Family History (Mother, Father and Siblings Health):

USE THE LETTERS BELOW TO INDICATE THE TYPE & LOCATION OF YOUR SENSATIONS RIGHT NOW

KEY: A= Ache B= Burning D= Dull Pain N= Numbness
P= Pins & Needles S= Stabbing O= Other



Total Body Health

Informed Consent to Chiropractic Adjustments and Care and Fee Schedule

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 muscles and ligaments 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 adjustments is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustments, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatments;

d) There are infrequent reported cases of burns or skin irritation associated 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.

I also acknowledge it is my responsibility to pay for the fees as set out, for chiropractic Services at the time services are rendered. First visit is $70.00 and Subsequent Visits are $50.00. Extended treatments if necessary are charged accordingly**. 24HRS NOTICE is required to cancel an appointment**. There will be a ***$40 fee for missed appointments or late cancellations***, except in the case of an emergency.

Dated this _____day of _____, 20_____

_____ _____

Patient signature (Legal Guardian) Witness of Signature

_____ _____

Name: Please Print Name: Please Print