

# Vitality Chiropractic Health Centre

## Dr. Percy Chan

Chiropractor

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**Welcome! This is what you can expect in your upcoming visits.**

### PAPERWORK

Please complete this simple admitting paperwork so we have an understanding of your past and current health situation.

### CONSULTATION

After viewing an introductory chiropractic video, you will meet the doctor and discuss your health concerns.

### EXAMINATION

We will conduct a thorough examination to locate the cause of your problem and determine if you are a candidate for chiropractic care. This includes a computerized assessment of how well your nervous system is communicating with your body. The assessment will include surface electromyography, which evaluates muscle function and balance, and dermo-thermography, which indicates any nerve irritation. The doctor may also need additional procedures, such as x-rays and a computerized gait analysis. If yours is a chiropractic case, we will develop a plan to help you.

### REPORT OF FINDINGS

Your second visit will begin with a video that will answer many of your questions. After that, we will explain the results of your examination. If we think that we can help you, we will recommend a schedule of care created just for you. During this time we will also explain our financial policies and determine your insurance coverage, if applicable.

### HEALTH TALK

We find that when patients are empowered to help themselves, they respond faster to care and remain healthier longer. This is why we offer you and those you care about an opportunity to attend our one-time evening session, where you will learn how to optimize your health.

**Please complete the following pages to save time and help us to serve you better.**

**Thank you.**

# PERSONAL HISTORY

NAME (LAST, FIRST)		BIRTHDATE (DD/MM/YY)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ADDRESS		APT #	CITY		PROVINCE
POSTAL CODE	E-MAIL ADDRESS @		HOME PHONE		WORK PHONE
FAMILY DOCTOR		PHONE NUMBER	EXTENDED HEALTH COVERAGE (PROVIDER/ GROUP #/ POLICY #)		
BUSINESS/EMPLOYER			OCCUPATION		
STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> COMMON-LAW					NUMBER OF CHILDREN/AGES
NAME OF EMERGENCY CONTACT		RELATIONSHIP TO YOU		PH. OF EMERGENCY CONTACT	
WHO MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?					

# CURRENT HEALTH CONDITION

CURRENT COMPLAINT(S)

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DOCTOR'S NAME:					
TYPE OF TREATMENT			RESULTS		
HOW LONG HAVE YOU HAD THIS CONDITION?	HAVE YOU HAD THIS CONDITION BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO		HEIGHT	WEIGHT	FOOT SIZE
IS THIS CONDITION RELATED TO YOUR: <input type="checkbox"/> JOB <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER:					DATE/TIME OF ACCIDENT
WHAT MAKES YOUR CONDITION WORSE? <input type="checkbox"/> SNEEZING <input type="checkbox"/> COUGHING <input type="checkbox"/> DEFACATION <input type="checkbox"/> SITTING <input type="checkbox"/> WALKING <input type="checkbox"/> STAIRS <input type="checkbox"/> BENDING <input type="checkbox"/> STANDING <input type="checkbox"/> LIFTING <input type="checkbox"/> OTHER:					
WHAT MAKES YOUR CONDITION FEEL BETTER? <input type="checkbox"/> BED REST <input type="checkbox"/> ICE <input type="checkbox"/> HEAT <input type="checkbox"/> MASSAGE <input type="checkbox"/> MEDICATION <input type="checkbox"/> OTHER:					
YOUR CURRENT COMPLAINT GETTING: <input type="checkbox"/> WORSE <input type="checkbox"/> CONSTANT <input type="checkbox"/> COMES AND GOES <input type="checkbox"/> BETTER					
CHARACTER OF PAIN: <input type="checkbox"/> DULL ACHE <input type="checkbox"/> SHARP <input type="checkbox"/> FIERY <input type="checkbox"/> TINGLING <input type="checkbox"/> STABBING <input type="checkbox"/> BURNING					IS THE PAIN: <input type="checkbox"/> CONSTANT <input type="checkbox"/> INTERMITTANT
PLEASE PLACE AN X ON THE GRADE BELOW, INDICATING THE SEVERITY OF YOUR PAIN.					
0 No pain		[ ]		10 Most pain ever felt	
PLEASE DESCRIBE HOW IT FEELS WHEN THIS PROBLEM IS AT ITS WORST.					
COMPARE THIS PROBLEM AT ITS WORST AND A TIME WHEN YOU FEEL GREAT. HOW DOES THIS PROBLEM AT ITS WORST INTERFERE WITH: YOUR ABILITY TO WORK:					
YOUR ABILITY TO ENJOY YOUR FAMILY OR YOUR SOCIAL TIME:					
YOUR ABILITY TO ENJOY YOUR HOBBIES OR SPORTS:					

WHICH OF THE ABOVE DOES YOUR CONDITION MOST INTERFERE?

IF YOU DO NOT GET THIS PROBLEM CORRECTED, DO YOU THINK IT WILL GET WORSE OVER THE NEXT FIVE YEARS?

YES  NO

DRUGS YOU NOW TAKE:

CHOLESTEROL  PAINKILLERS/MUSCLE RELAXERS  BLOOD PRESSURE MEDICINE  INSULIN  OTHER:

DO YOU SUFFER FROM ANY OTHER CONDITIONS?

IN WHAT POSITION DO YOU SLEEP?

SIDE  BACK  STOMACH

AGE OF MATTRESS (YEARS):

HAVE YOU HAD X-RAYS TAKEN IN THE LAST SIX MONTHS?

YES  NO IF YES, WHERE:

WHAT WERE THE RESULTS?

## PAST HEALTH HISTORY

### MAJOR SURGERY/OPERATIONS

- HERNIA       TONSILLECTOMY       GALL BLADDER       APPENDECTOMY       BACK SURGERY       BROKEN BONES  
 HYSTERECTOMY       C-SECTIONS       OTHER:

### CHILDHOOD TRAUMAS

### SPORTS INJURIES

### MOTOR VEHICLE ACCIDENTS

### WORK INJURIES

### HOSPITALIZATIONS (OTHER THAN ABOVE)

### PREVIOUS CHIROPRACTIC CARE

- NONE       DOCTOR'S NAME AND APPROXIMATE DATE OF LAST VISIT:

## FAMILY HEALTH HISTORY

### DOES ANY MEMBER OF YOUR FAMILY SUFFER FROM THE SAME CONDITION?

- NO     YES     WHOM:

### HAVE YOUR CHILDREN EVER HAD A SPINAL CHECK-UP?

- NO     YES     IF YES, WHERE AND WHEN?

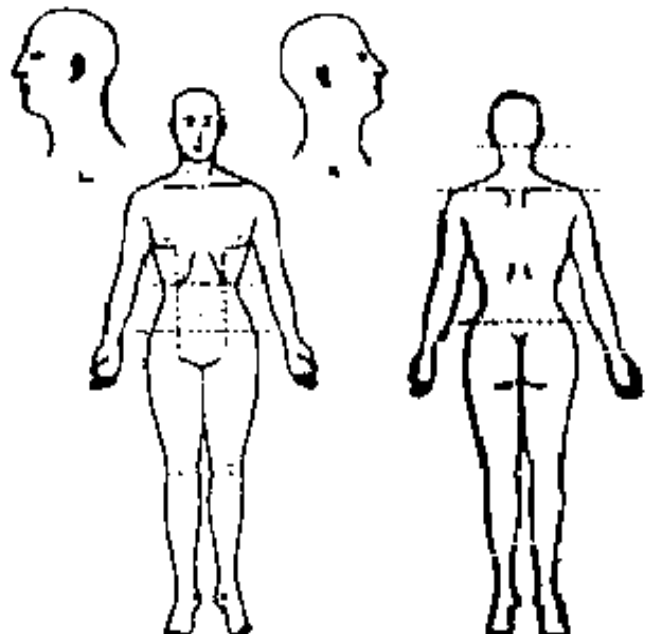
## SIGNS AND SYMPTOMS

When there is no interference, your nervous system controls the healthy function of virtually every cell, organ and system in the body. Carefully read the list below and please check any conditions that you may have experienced in the last six months. While some of the conditions may seem unrelated to the purpose of your appointment, always remember that nervous system interference may express itself in many ways.

- |  |   |
|--|---|
| <input type="checkbox"/> HEADACHES                       | <input type="checkbox"/> LIVER CONDITIONS                 |
| <input type="checkbox"/> MIGRAINE HEADACHES              | <input type="checkbox"/> JAUNDICE                         |
| <input type="checkbox"/> DIZZINESS                       | <input type="checkbox"/> SKIN CONDITIONS, ACNE OR PIMPLES |
| <input type="checkbox"/> FATIGUE                         | <input type="checkbox"/> STOMACH PROBLEMS                 |
| <input type="checkbox"/> HEAD COLDS                      | <input type="checkbox"/> INDIGESTION                      |
| <input type="checkbox"/> VISION PROBLEMS                 | <input type="checkbox"/> HEARTBURN                        |
| <input type="checkbox"/> HEARING PROBLEMS                | <input type="checkbox"/> GASTRITIS                        |
| <input type="checkbox"/> SINUS PROBLEMS                  | <input type="checkbox"/> ULCERS                           |
| <input type="checkbox"/> COMMON COLD                     | <input type="checkbox"/> BLOOD SUGAR PROBLEMS             |
| <input type="checkbox"/> ALLERGIES                       | <input type="checkbox"/> KIDNEY PROBLEMS                  |
| <input type="checkbox"/> RUNNY NOSE                      | <input type="checkbox"/> GAS PAINS                        |
| <input type="checkbox"/> SORE THROAT                     | <input type="checkbox"/> CHRONIC TIREDNESS                |
| <input type="checkbox"/> TONSILLITIS                     | <input type="checkbox"/> IRRITABLE BOWEL                  |
| <input type="checkbox"/> HOARSENESS                      | <input type="checkbox"/> CONSTIPATION OR DIARRHEA         |
| <input type="checkbox"/> LARYNGITIS                      | <input type="checkbox"/> HERNIAS                          |
| <input type="checkbox"/> STIFF NECK                      | <input type="checkbox"/> STERILITY                        |
| <input type="checkbox"/> COUGH                           | <input type="checkbox"/> BLADDER PROBLEMS                 |
| <input type="checkbox"/> CROUP                           | <input type="checkbox"/> MENSTRUAL PROBLEMS               |
| <input type="checkbox"/> PAIN IN THE UPPER ARM           | <input type="checkbox"/> MENSTRUAL CRAMPS                 |
| <input type="checkbox"/> TENNIS ELBOW                    | <input type="checkbox"/> BED WETTING                      |
| <input type="checkbox"/> WRIST, HAND AND FINGER NUMBNESS | <input type="checkbox"/> KNEE PAINS                       |
| <input type="checkbox"/> WRIST, HAND AND FINGER PAIN     | <input type="checkbox"/> SCIATICA                         |
| <input type="checkbox"/> SHORTNESS OF BREATH             | <input type="checkbox"/> LOW BACK PAIN                    |
| <input type="checkbox"/> DIFFICULTY IN BREATHING         | <input type="checkbox"/> DIFFICULT OR PAINFUL URINATION   |
| <input type="checkbox"/> ASTHMA                          | <input type="checkbox"/> NUMBNESS IN LEGS                 |
| <input type="checkbox"/> HEART CONDITIONS                | <input type="checkbox"/> POOR CIRCULATION IN LEGS         |
| <input type="checkbox"/> CHEST PAINS                     | <input type="checkbox"/> SHIN SPLINTS                     |
| <input type="checkbox"/> BRONCHITIS                      | <input type="checkbox"/> SWOLLEN ANKLES                   |
| <input type="checkbox"/> PNEUMONIA, CONGESTION           | <input type="checkbox"/> WEAK ARCHES                      |
| <input type="checkbox"/> GALLBLADDER CONDITIONS          | <input type="checkbox"/> LEG CRAMPS OR COLD FEET          |
| <input type="checkbox"/> HIATAL HERNIA                   | <input type="checkbox"/> SACROILIAC PROBLEMS              |
| <input type="checkbox"/> BLOOD PRESSURE PROBLEMS         | <input type="checkbox"/> HEMORRHOIDS                      |
|  | <input type="checkbox"/> PAIN AT THE END OF THE SPINE     |

Please outline on the diagram the area of your discomfort and any radiation of pain using the appropriate symbol.

Numbness      Pins and needles      Burning      Ache      Stabbing  
 -----      **0000**      **XXXX**      **\*\*\*\***      **////**



# WHY ARE YOU HERE TODAY?

People seek chiropractic care for a variety of reasons. Some are looking for **relief care**. Others are interested in **corrective care**. Still others want **preventative/maintenance care**. These are the three phases of care. Your doctor will consider your needs and desires when recommending your schedule of care. Remember that your prepared recommendation is an incorporation of all three phases of care. What is your goal of care?

- Preventative/Maintenance care**  
I would like my body to function at its highest state possible.
- Corrective care**  
I want to correct the cause of my problem corrected and relief from my symptoms.
- Relief care**  
I only want to be relieved from my current symptoms.

## What are you hoping to achieve on your first visit with us today?

# PLEASE READ CAREFULLY

In order for the Doctor of Chiropractic indicated below to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiographic examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by the Chiropractor indicated below, or any party authorized to do so by that Chiropractor.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that Chiropractic care is considered very safe with an extremely low risk rate by any standard. I further understand that there are, however, some risks (rib fractures and strokes) associated with chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.*

**I have read and understood the above, and I have had sufficient opportunity to discuss it's content with the Doctor of Chiropractic indicated below. I do hereby request and consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic indicated below, for my present condition and for any future conditions for which I may seek care. I also agree to payment for all services rendered.**

Name (printed) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ D.C. \_\_\_\_\_ Initial \_\_\_\_\_