

Dr. Christopher Notley

www.DrNotley.com

Please fill out this intake form. It should take between 5 to 10 minutes to complete. Then print the document, double sided, and fill in the chart and sign the document. Please bring the document to your first visit. Answer what you can. Further questions will be asked during your first visit.

PATIENT INTAKE:

Name _____ Date of Birth (MM/DD/YYYY) _____

Address _____
Unit/Street number _____ City _____ Province _____ Postal Code _____

Contact phone numbers: _____ / _____ E-mail _____

Occupation _____ Employer _____

Provincial Health Care Card _____ Insurance plan & number: _____

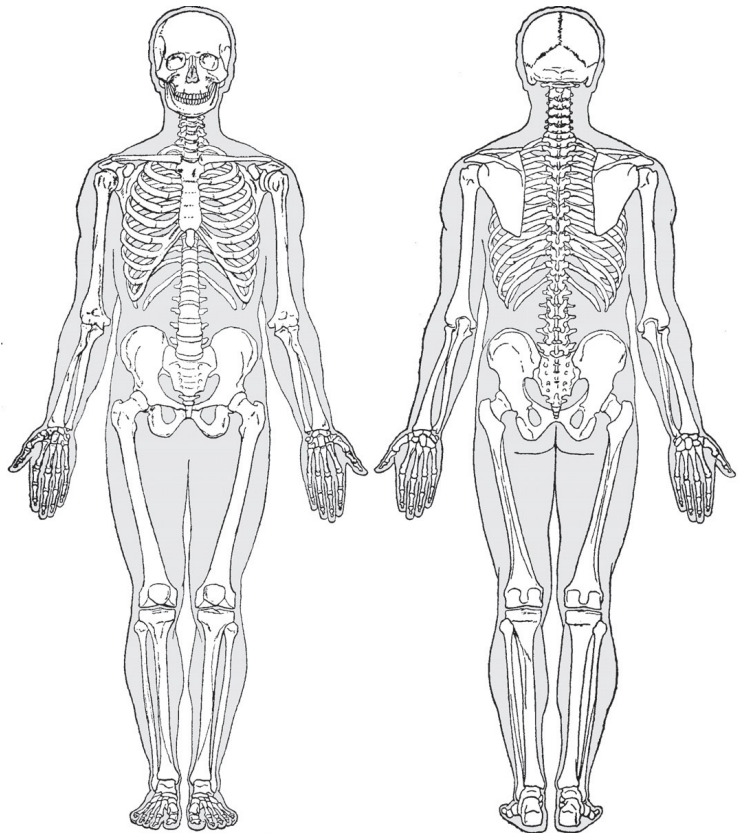
Recent motor vehicle accident (MPI) Yes / No MPI Claim Number _____ Date of Accident: _____

Work related injury / accident (WCB) Yes / No WCB Claim Number _____ Date of Accident: _____

How did you learn about our office?

Reason for consulting this office:

1. What is your reason for this appointment?
2. Was there a particular mechanism that caused this to occur? How?
3. When did it start?
4. Describe your discomfort.
5. Indicate the areas on the diagram where you feel any of the following symptoms:
 - Numbness
 - Pins & Needles
 - Burning
 - Aching
 - Stabbing
 - Soreness
 - Stiffness
 - Pain
6. On a scale of 0 to 10 how would you rate your discomfort? Zero is no discomfort and 10 is the worst discomfort imaginable.
7. Is the discomfort **CONTINUOUS** or **PERIODIC**?
(circle)
8. Is it getting better, worse, or staying the same (circle)
9. Is there a time of day that there is more discomfort?



10. What positions, activities or movements make it worse?

11. What positions, activities or movements make it better?

Past medical history

1. Has this discomfort happened before?
2. Were you treated for it? By whom?
3. Did the discomfort resolve?
4. Please list any past muscle and joint injuries, past motor vehicle accidents, surgeries or hospitalizations

Have you been diagnosed with, in the past or present, any of the following medical conditions? (circle)

Cancer	Asthma
Diabetes	Hyperthyroidism
Hypertension	Hypothyroidism
Heart Disease	Other

PERSONAL HEALTH HISTORY:

1. On average, how would you describe your health? Poor Neutral Good Excellent
2. Are you currently or do you regularly suffer from the following symptoms?

Please circle symptoms.

Headaches	Fatigue	Loss of balance	Loss of appetite
Chest pain	Nervousness	Visual problems	Hearing changes
Fever	Depression	Night sweats	Nausea/vomiting
Dizziness	Abdominal pain/diarrhea	Frequent heart burn	Menstrual irregularities
Shortness of breath	Constipation	Weight change	Coordination problems
Fainting	Loss of memory	Intolerance to heat or cold	
Bowel/Bladder problems	Cold sweats	Difficulty speaking	

MEDICATIONS YOU NOW TAKE: (please circle)

Anti-inflammatory	Blood Pressure	Birth Control Pills
Pain Killers	Tranquilizers	Cholesterol
Muscle Relaxants	Insulin	Thyroid

Other medication: _____

Date of Last Medical Examination: _____

I acknowledge to the best of my knowledge that this information is accurate and true.

SIGNATURE

DATE

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of Chiropractic. In particular you should note:

- While rare, some patients may experience short term aggravation of symptoms of 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;

- 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 rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of 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;

- There are 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;

- 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 adjustment.

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: _____