INFORMATION/NEW FILE

ORDRE DES CHIROPRATICIENS DU QUÉBEC

Last name: ______ First name: ______ Date of birth: (M/D/Y) ______

Civil status: Married ☐ Living common-law ☐ Single ☐ Divorced ☐ Widowed ☐ Other ☐ Sex: ______

Address: ______ City: ______ Postal code: ______

Home phone: ______ Cell phone: ______

Office phone: ______ E-mail: ______

What is the best way to reach you? Home phone ☐ Cell phone ☐ Office phone ☐ E-mail ☐

Do you authorize the clinic to contact you by e-mail? Yes ☐ No ☐

Do you authorize the clinic to leave a message at the specified number to confirm an appointment? Yes ☐ No ☐

Occupation: ______ Are you currently on leave from work? Yes ☐ No ☐

Do you have any children? Yes ☐ No ☐ If so, how many? ______

Referred by: Other professional ☐ Name: ______ Clinic: ______

Spouse ☐ Friend ☐ Parent ☐ Co-worker ☐ Name: ______

Advertisement ☐ Website ☐ Yellow Pages ☐ Facebook ☐ Google ☐ Other ☐ : ______

Name of your family physician: ______

Last appointment: ______ Date of last medical examination: ______

Have you ever consulted a chiropractor? Yes ☐ No ☐

Who? ______ When? ______

Are you consulting for a problem related to an occupational accident (CNESST)? Yes ☐ No ☐

Are you consulting for a problem related to a car accident (SAAQ)? Yes ☐ No ☐

Name of representative: ______ File number: ______

Is your treatment covered by a Veterans Program or IVAC? Yes ☐ No ☐

Do you agree to have us reply to requests made by your insurer, Veterans Affairs Canada, IVAC, the CNESST or the SAAQ regarding your treatment dates and the amounts paid for those treatments? Yes ☐ No ☐

Person to contact in case of emergency:

Last name: ______ First name: ______ Telephone number: ______

Relationship: ______

I hereby authorize the chiropractor to conduct the examinations that he or she deems necessary in order to open my file. Some patients may feel soreness or a slight aggravation of symptoms following the examination. Although these symptoms generally do not last long, it is important to mention them to the chiropractor at your next appointment.

Patient's signature or signature of person responsible: ______

Date : ______

Initial Condition

Circle problematic areas

Type of Pain:

___Tension

___Stabbing

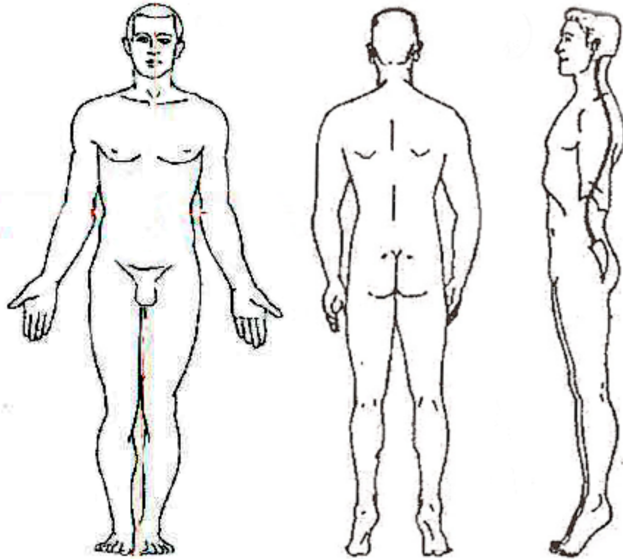
___Sharp

___Numbness

___Burning

___Throbbing

___Other: _______________



Problematic areas	Since when?	How did it appear?
1-________________________	1-________________________	1-__________________________
2-________________________	2-________________________	2-__________________________
3-________________________	3-________________________	3-__________________________

Intensity level (1-10) beggining:___ now:___

Variation during the day (ex. worse in the morning)?____

What factors increase the pain:____

What factors decrease the pain:____

Are there other associated symptoms?____

Have you been treated for this problem in the past?

Yes____, No____ By who?____

Since this problem appeared, what bothers you the most in every day life?

____

Medications:
1-___________________________________
2-___________________________________
3-___________________________________
4-___________________________________

Why:
____
____
____
____

Previous Injuries:
Injury:________________________ Outcome:_____________________Date:_____________
Injury:________________________ Outcome:_____________________Date:_____________
Injury:________________________ Outcome:_____________________Date:_____________

Previous surgery:
Surgery:_____________________ Outcome:_____________________Date:_____________
Surgery:_____________________ Outcome:_____________________Date:_____________
Surgery:_____________________ Outcome:_____________________Date:_____________

Previous or present diseases:
Disease:_____________________ Outcome:_____________________Date:_____________
Disease:_____________________ Outcome:_____________________Date:_____________
Disease:_____________________ Outcome:_____________________Date:_____________

Other hospitalizations:____

When was your last exam:

	-6 months	6 months -1 year	+1 year	Never
Chiropractic				
Radiology				
Physical				
Blood				
Urinary				

Daily habits:

	Day	Week
Coffee (cups)		
Smoking (cigarettes)		
Alcohol (glasses)		
Sleep (hours)		X
Exercise (hours)		

How would you rate your current health status:

___Excellent ___Very good ___Good ___Average ___Poor ___VeryPoor

General health

Blank: Never **O: Occasional** **F: Frequent** **C: Constant**

NERVOUS SYSTEM	OFC	MUSCLES AND JOINTS	OFC	GASTRO-INTESTINAL	OFC
Allergies		Arthritis		Bloated	
Dizziness		Bursitis		Colitis	
Fainting		Herniated discs		Constipation	
Fatigue		Pain in:		Diarrhea	
Headaches		Neck		Poor digestion	
Migraines		Upper back		Excessive hunger	
Weight loss		Mid back		Reflux/burning	
Trouble sleeping		Low back		Naushea	
Anxiety/Stress		Sciatic region		Vomitting	
Depression		shoulder, arm, elbow, wrist, hand		Stomach pain	
EYES, EARS AND NOSE	OFC	Hip, thigh, knee, ankle, foot		Low appetite	
Asthma		CARDIOVASCULAR	OFC	GENITOURINARY	OFC
Colds		High/Low pressure		Bed wetting	
Eye pain		Chest pain		Blood in urine	
Tinnitus		Bad circulation		Kidney infection	
Reduced sight		RESPIRATORY	OFC	Pain while urinating	
Nose bleeds		Chronic cough		Prostate pain	
Sinus infections		Difficulty breathing		SKIN	OFC
Throat aches		Wheezing		Dry skin	
				Itching	
				Varicose veins	

Family History

___Arthritis Family relationship:________________________

___Asthma Family relationship:________________________

___Cancer, which:__________________ Family relationship:________________________

___Diabetes Family relationship:________________________

___High blood pressure Family relationship:________________________

___Heart problems Family relationship:________________________

___Stroke Family relationship:________________________

___Pulmonary problems Family relationship:________________________

___Renal problems Family relationship:________________________

___Gastro-intestinal problems Family relationship:________________________

___Nervous system problems Family relationship:________________________

___Back Problems Family relationship:________________________

___Scoliosis Family relationship:________________________

___Other:__________________________ Family relationship:________________________

Section for women

Is your menstrual cycle

___Normal ___Irregular ___Absent

During your period, do you feel:

___Cramps ___Back pain ___Weak ___Migraines ___Other

____

How many times have you had: Pregnancies___

Births___

Cesareans___

Do you use an oral contraceptive ___Yes ___No

Do you take Hormones ___Yes ___No

Are you pregnant ___Yes ___No

CONSENT TO CHIROPRACTIC TREATMENT

ORDRE DES CHIROPRATICIENS DU QUÉBEC

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor, to be familiar with the proposed treatment procedure and to make an informed decision about proceeding with treatment, in accordance with Section 43 of the *Code of ethics of chiropractors*.

Chiropractic treatment may include adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue (muscles and other supporting tissues) techniques, and other forms of therapy including, but not limited to, electrical or light therapy and prescribed exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for various issues affecting the neck, back and other areas of the body caused by nerve, muscle, joint and related tissue dysfunction. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve joint, muscle and nervous system 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 and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** — Although current medical and scientific evidence does not indicate that chiropractic treatment causes artery damage or stroke, chiropractic treatment has, in rare cases, been associated with stroke. Such cases can, however, be explained by a previously damaged artery or by the fact that the patient was progressing toward a stroke when he or she consulted the chiropractor.

  Many 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.

Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either 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.

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 my health status and the nature of the problem to be treated, the proposed treatment plan and the potential benefits and risks with the chiropractor.

I hereby declare that I have been informed of the alternatives to the proposed treatment.

I hereby declare that I have been given all the information and explanations needed to provide free and informed consent to the treatment proposed by the chiropractor.

I hereby declare that I have been informed that I can withdraw my consent at any time and that any significant changes to the proposed treatment plan will be subject to a separate consent.

Name (Please print) | Signature of patient (or legal guardian) | Patient's date of birth

Full name of chiropractor (Please print) | Signature of chiropractor | Date 20

Informed consent to treatment must be adapted to the patient and take any changes in his or her condition into account. The aim of this table is to document these changes and ensure that the patient is well informed of the benefits and risks related to the treatment received and his or her condition. Chiropractors are asked to specify the new reasons for consultation and the areas of the body where treatment will be applied or changed. They must also ensure that they have the patient's consent following this update and once the patient has received explanations regarding the proposed changes.

INFORMED CONSENT REMINDER			
Date	Area of the body concerned or change in treatment	Signature of patient	Signature of chiropractor