

Dr Darren Poncelet, B.Sc., D.C.
M & Y Chiropractic Health and Wellness Centre
Confidential Health History Report

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Aneurism | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Herpes/shingles | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Scarlet fever |
| Type: _____ | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Sjogren's |
| Type: _____ | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles | <input type="checkbox"/> Spinal cord Injury |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hardening of the arteries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing impaired | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Whooping cough |

DATE OF LAST:	6 mths	6-18	18+	Never	HABITS:	Heavy	Moderate	Light	None
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; this information about your family members will give us a better picture of your total health.)

NAME:	AGE:	RELATION:	PAST & PRESENT HEALTH PROBLEMS:

Please list any additional comments regarding your health and well-being: _____

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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:

- a) While rare, some patients may experience short-term aggravation of symptoms or muscle and ligamentous 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 have been 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 a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.
- c) There are rare reported cases of disc injuries following manual cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.
- d) 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 discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (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 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 Signature

Patient Name (please print)

Witness Name (please print)