Dr Darren Poncelet, B.Sc., D.C.
MY Chiropractic Health and Wellness Centre
Confidential Health History Form

Date: ________________________

Last Name: _____________________________________ First Name: ____________________________M/F/O

Address: ________________________________ City: __________________ Postal Code: __________________

Phone# (H): ______________________ (W): _______________________ (C): __________________________

D.O.B. ______/______/_______ Email Address: ____
day month year

Emergency Contact Name: ________________________________ Phone#:_______________________________

How were you referred to our clinic? ____
(person's name, phone book, signs, etc…)

* *

Reason for your visit today? ____

What would you like to accomplish with our treatments? ____

How long has it been since you really felt good? ____

Are you under medical/therapeutic care? ☐ yes ☐ no For what condition?

____

Previous Traumas, Operations and Diagnosed Medical Conditions: _______________________________________

____

Medications you presently take: ____

Vitamins / Supplements you presently take: ____

Please list any known allergies: ____

Height: ________Weight: ________ Blood Pressure: __________ Pregnant? yes ☐ no ☐ Due Date:__________

Do you sleep well? ☐ yes ☐ no What position do you sleep in?____

Regular exercise? ☐ yes ☐ no Type of exercise / frequency:____

Do you wear orthotics (custom arch supports)? yes ☐ no ☐

Occupation: ________________________ Activities: ____

How stressed are you? (**0** = no stress……..**10** = nervous breakdown) **0** 1 2 3 4 5 6 7 8 9 **10**

	NAME:	**ADDRESS:**	**PHONE #:**
Current Chiropractor:			
Current Massage Therapist:			
Current Naturopath:			
Current Medical Doctor:			

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Please check the following conditions that apply to you. ***O*** – Occasionally ***F*** – Frequently ***C*** – Constantly

GENERAL

O F C

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Confusion
☐ ☐ ☐ Depression
☐ ☐ ☐ Difficulty concentrating
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Forgetfulness
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Headaches/migraines
☐ ☐ ☐ Hernia
☐ ☐ ☐ Loss of balance
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness
☐ ☐ ☐ Painful tailbone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Swollen joints
☐ ☐ ☐ Tremors
Other: _____

EYES, EARS, NOSE & THROAT

☐ ☐ ☐ Dryness
☐ ☐ ☐ Ear infections
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Glasses/contacts
☐ ☐ ☐ Loss of taste
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Repetitive colds
☐ ☐ ☐ Ringing in ears
☐ ☐ ☐ Sinus problems
Other: _____

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Bladder infection
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control bladder
☐ ☐ ☐ Kidney infection/stones
☐ ☐ ☐ Painful/burning urination
☐ ☐ ☐ Prostate problems
Other: _____

CIRCULATORY/RESPITORY

O F C

☐ ☐ ☐ Anemia
☐ ☐ ☐ Arrhythmia
☐ ☐ ☐ Asthma
☐ ☐ ☐ Bronchitis
☐ ☐ ☐ Blood clots
☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Cold feet/hands
☐ ☐ ☐ Cold sweats
☐ ☐ ☐ Difficulty breathing
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Night sweats
☐ ☐ ☐ Pain over heart/angina
☐ ☐ ☐ Palpitations
☐ ☐ ☐ Swelling of ankles
☐ ☐ ☐ Varicose veins
☐ ☐ ☐ Wheezing
Other: _____

SKIN

☐ ☐ ☐ Acne
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Change in mole
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives
☐ ☐ ☐ Itching
☐ ☐ ☐ Rashes
☐ ☐ ☐ Warts
Other: _____

FOR WOMEN ONLY

☐ ☐ ☐ Breast tenderness
☐ ☐ ☐ Excessive flow
☐ ☐ ☐ Fertility concerns
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ PMS
☐ ☐ ☐ Vaginal discharge
☐ ☐ ☐ Vaginal itching
Other: _____

DIGESTIVE

O F C

☐ ☐ ☐ Abdominal bloating
☐ ☐ ☐ Abdominal pain
☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Heartburn
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting blood
☐ ☐ ☐ Poor appetite
Other: _____

MUSCLE & JOINT

☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Neck pain/stiffness
☐ ☐ ☐ Pain btwn shoulders
Other: _____

PAIN OR NUMBNESS IN

☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Feet
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Jaw
☐ ☐ ☐ Knees
☐ ☐ ☐ Legs
☐ ☐ ☐ Shoulders
Other: _____

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PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

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

DATE OF LAST:	6 mths	6-18	18+	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest x-ray	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

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)

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OFFICE POLICIES FOR PATIENTS

It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

UPON ARRIVAL

Please remove your shoes and check in at front desk. Fill out any necessary forms and return them to front desk. One of our health team members will escort or direct you to your adjusting or treatment room.

Chiropractic – Once you are in an adjustment room please empty your pockets (keys, wallet etc.) and remove any earrings and long necklaces. **Please lie face down on the table as this will relax your muscles and take the stress of gravity off your spine thus facilitating a more comfortable adjustment.**

Registered Massage Therapy, Naturopathic Medicine and Alternative Therapies – Once in your treatment room your practitioner will discuss treatments for the session. This may include areas to be treated, your position on the table, benefits/risks, today's goals and a verbal consent will be obtained before the treatment commences. If you want to change or refuse any part of the treatment at any time you have the right to do so. Your practitioner will then leave the room so that you may undress if necessary and re-enter the room once you are ready. You are covered with sheets at all times; only the area being worked on will be uncovered.

After the treatment your practitioner will suggest a treatment schedule to best suit your individual situation. They may also recommend after care exercises or stretching to further enhance your treatments. You may be asked to complete some paperwork between your treatments to allow your practitioner to fully understand the nature of your issues. Those who follow these recommendations notice better and longer lasting results.

YOUR SCHEDULE

Your specific course of care has been designed just for you by your Health Care Provider and your appointment time has been set aside specifically for you. The importance of keeping your appointments and being on time is crucial to help make our office as efficient as possible for the benefit of all our patients. If you do need to reschedule an appointment we require a minimum of 24 hours notice. Any missed appointments or cancellations without adequate notice may result in a fee being charged to you. Due to the healing nature of your treatments, we request that any missed or cancelled sessions be made up at the earliest available time, ideally within 24 hours. Please understand that as a patient you are responsible for any and all charges incurred during the course of your treatment at our wellness centre. When seeing multiple health team members we will do our best to align your appointments together because we value your time as well. If requested, a personal appointment calendar can be supplied to you.

REFERRALS

Once you understand the importance and benefits provided by each of our Health Care Providers, we are confident that you will want everyone in your family checked. The nicest compliment you can give our clinic is to refer us to your family and friends. Please feel free to ask anyone on our health team for any literature you may require.

Welcome to our Health and Wellness Family.

I agree and understand the above policies. Signed_____

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