ABERFOYLE FAMILY CHIROPRACTIC

"Natural care for all ages"

Name:____ Date:______________

Address:_______________________________ City:____________ Postal Code:_________

Date of Birth: / / Gender: M F Marital Status: S M D W No of Children :______
Month Day Year

Tel #s: Res: ( ) Cell: ( ) Bus: ( )___________________

Occupation: _____________________________ E-Mail: _________________________________

Who referred you to our clinic? ____

What health issues have brought you here today? (Check one or more)

Wellness Consult € *Spinal Check-up* *Back Pain* *Neck Pain* *Leg Pain* *Headache* Other

YOUR HEALTH PROFILE

Have you been to a Chiropractor previously? Yes When: __________ Doctor: _______________________

WHY THIS IS IMPORTANT:
As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our first goal is to address the issues that brought you here and secondly, to offer you the opportunity of continually improving your health and wellness. Stresses can accumulate over many years and affect your health. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime"

CHILDHOOD (to age 17)	**Y**	**N**	**Unsure**	**ADULTHOOD (18 to present)**	**Y**	**N**	**Unsure**
Did you have any serious falls?	☐	☐	☐	Do/did you smoke?	☐	☐	☐
Did you play contact sports?	☐	☐	☐	Do/did you drink alcohol?	☐	☐	☐
Did you have any surgery?	☐	☐	☐	Have you had any surgery?	☐	☐	☐
Were you involved in any car accidents?	☐	☐	☐	Were you involved in any accidents (car or work?)	☐	☐	☐
Was there any prolonged use of Medicine (e.g. inhaler, Antibiotic?)	☐	☐	☐	Is there any prolonged use of medicine (eg. inhaler, Antibiotics?)	☐	☐	☐
Were you under Chiropractic care as a child?	☐	☐	☐				

On a scale of 1 to 10, describe your stress level (circle one)

Personal:	1	2	3	4	5	6	7	8	9	10
Occupational:	1	2	3	4	5	6	7	8	9	10

On a scale of Poor, Good or Excellent, describe your:
Diet:___________ Exercise: _______________ Sleep: _______________ General Health: _________________

Do you take medications regularly for:

☐ Heart ☐ Depression ☐ Diabetes ☐ Pain ☐ Arthritis ☐ Sleep ☐ Other

PLEASE TURN OVER

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR CLINIC

If you experiencing pain, is it:

☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐ Radiating ☐ Other __________

Did it occur: ☐ Suddenly ☐ Gradually

How would you rate your pain on a scale of 1 – 10 (circle one)

Mild	1	2	3	4	5	6	7	8	9	10	Severe____

Since the problem started, is it: ☐ About the same ☐ Getting Better ☐ Getting Worse

What makes it worse?____

Does it interfere with:

☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure ☐ Other ____________

Other Doctors/Therapists seen for ***this*** problem (please list):

Chiropractor: _____________________________________

Medical Doctor : _____________________________________

Other: _____________________________________

Please check the conditions for which you have been treated:

☐ Ear Infections	☐ Eczema	☐ Heart Disease	☐ Indigestion
☐ Sinus Conditions	☐ Bronchitis	☐ Depression	☐ Cancer
☐ Food Allergies	☐ Dizziness	☐ Stroke	☐ Concussion
☐ Asthma	☐ Blood Pressure	☐ Ulcers	☐ Broken Bones

Our Clinic is dedicated to assisting you in recovering your health naturally. Please review the next paragraph and sign in the area provided.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment to the Doctor. All fees are due at time of service.

I hereby request and consent to the performance of Chiropractic examinations, adjustments and other chiropractic procedures such as but not limited to orthotics, SpineForce and Creating Wellness, and if necessary, diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic/staff members named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic, there are some very slight risks to treatment, including but not limited to, muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read the above Consent. I have also had an opportunity to ask questions about it's content and by signing below, I agree to the above mentioned chiropractic procedure. I intend this Consent Form to cover the entire course of treatment for my present condition.

Signature: ____ Date: ________________________

ABERFOYLE FAMILY CHIROPRACTIC
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DR. PETER FRASER