Woodroffe Chiropractic Clinic
& MASSAGE THERAPY

CONFIDENTIAL CASE HISTORY

Your answers will help us determine if our care can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

DATE:

PERSONAL INFORMATION

Name: ______________________ **E-MAIL:** ______________________

How do you wish to be addressed in our office? ☐ First Name ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr.

Address: ______________________ City: ______________________

Postal Code: ____________ Home Phone: ____________ Business ______________________

Date of Birth: yy____mm____dd____ Cell Phone ______________________

Employer: ______________________ Address: ______________________

Occupation: ______________________

Spouse/Partner's Name:____________ How many children do you have? (Age and Gender)

Who may we thank for referring you to our office? ______________________

How did you hear about us? If it was "Google", tell us what you typed as a search term. ______________________

OTHER PROVIDERS

Have you consulted a chiropractor previously? Y N Chiropractor's Name: ______________________

When was your last visit? ____________ What was the problem?______________________

Was the experience a good one? Yes No

Family Doctor's Name: ____________ Address: ______________________ Tel: ____________

REASON FOR CONSULTING OUR OFFICE

Stress Symptoms

☐ Headache/Migraine
☐ Dizzy
☐ Ringing in ears
☐ Blurring of vision
☐ Poor concentration
☐ Loss of sleep
☐ Depression
☐ Decreased energy
☐ Irritability

Females Only!

☐ Painful menses
☐ Irregular menses
☐ Fibroids

Muscle/Joint/Bone

☐ Backache
☐ Neck pain
☐ Arm/hand pain or tingling
☐ Leg/foot pain or tingling
☐ Tension/pain in shoulders
☐ Scoliosis
☐ Osteoporosis
☐ Osteoarthritis

Digestive

☐ Gall bladder pain
☐ Heartburn
☐ Constipation
☐ Loose stool
☐ Stomach pains

Neurological

☐ Seizures
☐ Fainting
☐ Convulsions
☐ Loss of balance
☐ Vertigo
☐ Tremors

Ears Nose Throat

☐ Earache
☐ Sinus trouble
☐ Chronic runny nose
☐ Allergies
☐ I am a smoker
☐ Cancer in my history
☐ Cancer in my family

Cardiorespiratory

☐ Asthma
☐ Chest pain
☐ COPD
☐ Emphysema
☐ Chronic cough
☐ Heart palpitations
☐ Racing heart
☐ High blood pressure
☐ Stroke / Heart attack

Genitourinary

☐ Painful voiding of bladder
☐ Blood in urine
☐ Urgency
☐ Enlarged prostate

List any prescription drugs you are taking. ______________________

Are you pregnant? Circle one. Yes No

I hereby consent to a hands-on physical examination. I also certify that the information I have provided is true and complete.

Patient Signature: ______________________ **Date:** ______________________

Name: ______________________

1. Pain Intensity

No pain	Mild pain	Moderate pain	Worst possible

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc)

No pain, no restrictions	Mild pain but no restrictions	Moderate pain: moving slowly	Moderate pain: need some assistance	Severe pain: need 100% assistance

4. Travel (driving , riding bus etc.)

No pain on long trips.	Mild pain on long trips.	Moderate pain on long trips	Moderate pain on short trips.	Severe pain on short trips.

5. Work

Can do usual work plus unlim-ited extra work.	Can do usual work but no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Worst possible

7. Frequency of Pain

No pain	Occasional pain: 25% of day	Intermittent pain: 50% of day	Frequent pain: 75% of day	Constant pain 100% of day

8. Lifting

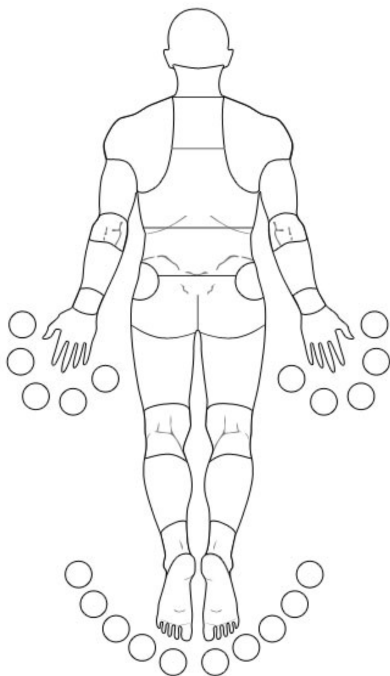
No pain w/ heavy weight	Increased pain w/ heavy weight	Increased pain w/ moderate weight	Increased pain w/ light weight	Increased pain w/ any weight

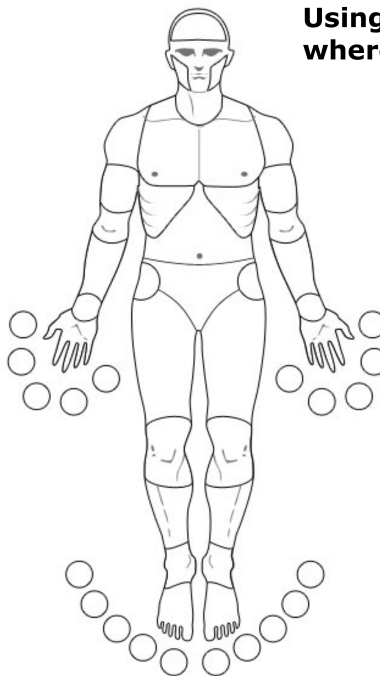
9. Walking

No pain any distance	Increased pain after 1 km	Increased pain after 1/2 km	Increased pain after 250m	Increased pain all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 30 min	Increased pain w/ any standing





Using a pen, carefully show us where your symptoms are.

Woodroffe Chiropractic Clinic

1435 Woodroffe Ave,
Nepean, ON. K2G 1W1
(613) 224 8543

INFORMED CONSENT TO EXAMINATION AND X-RAY

I hereby request and consent to the performance of a Chiropractic, Orthopaedic, and Neurological examination and diagnostic x-rays (if required) which will determine if Chiropractic can help me. I understand that in some cases, the examination may aggravate my present condition.

NAME:____________________ **SIGNATURE:**____________________ **DATE:**__________

FOR WOMEN ONLY:

Date of last period? ___________________ Are you pregnant? ☐YES ☐NO ☐MAYBE

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, custom foot orthotics or subsequent diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that the 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 treatments, including, but not limited to, muscle strains and sprains, rib fractures, disc injuries and stroke. 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, and is in my best interests.

I have read the above consent for chiropractic adjustments and care.

I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE TO THE ABOVE NAMED PROCEDURES.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

______________________________ ______________________________

PATIENT'S NAME (please print) **SIGNATURE OF PATIENT (or parent/guardian)**

______________________________ ______________________________

DATE SIGNED **WITNESS TO SIGNATURE ABOVE**

Dr. Delorme
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