ATLAS CHIROPRACTIC & MASSAGE THERAPY

Dr. Karlo Pavich B.Sc., D.C.

Patient Personal/Confidential Data

No: _____ (Office Use Only) Date: _____

Name: (□ Mr □ Mrs □ Ms □ Miss □ Dr): _____ Age: _____ D.O.B. D___ M ___ YR _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____ Employer: _____

Marital Status: □ Married □ Single □ Other: _____ Children: _____

Who (or what source) referred you?: _____

Name of your insurance company: _____

Major complaint: _____ Is this related to an accident? □ Yes □ No

How did the accident occur?: □ Motor Vehicle □ Workplace □ Other: _____

Other Doctor(s) seen for this condition: _____

Previous Chiropractic Care: □ No □ Yes, Doctor's name: _____

Have you been treated by a Doctor for any health condition in the last year? □ Yes □ No

If yes, please describe: _____

_____

Informed Consent To Chiropractic Examination

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes, or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays, will be performed on you to minimize this risk to yourself.
Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions.
If you have any questions about this, please ask your chiropractor.

If you have read the above statement and consent to an examination and testing:

Patient Signature: _____

Health Questionnaire

Please identify each of the conditions below that you are currently experiencing or have experienced within 3 months.

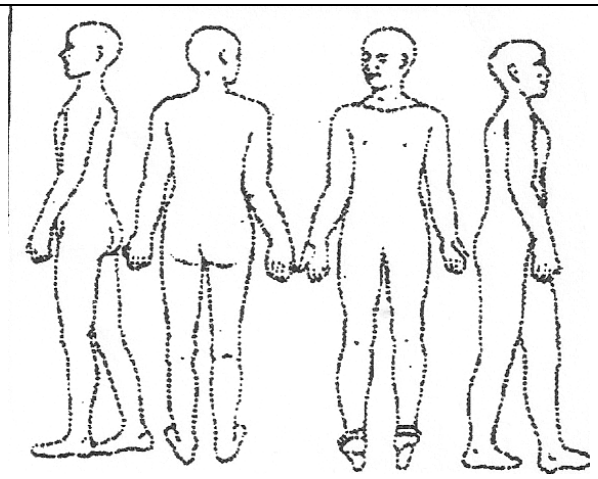
Patient Name: _____ No: _____ (office use only)

Musculo-Skeletal System
□ Low back pain
□ Mid back pain
□ Pain between shoulders
□ Neck pain
□ Arm problems
□ Leg problems
□ Foot problems
□ Swollen joints
□ Painful joints
□ Stiff joints
□ Sore muscles
□ Weak muscles
□ Walking problems
□ Spasms
□ Broken bones
□ Shoulder pain

Geniro-Urinary System
□ Bladder trouble
□ Excessive urination
□ Painful urination
□ Discolored urine

Female
□ Vaginal discharge
□ Vaginal bleeding
□ Vaginal pain
□ Breast pain
□ Lumps on breast(s)

Are you pregnant?
(female only)
□ Yes
□ No



Symptom Localization Chart

P ____ Pain T ____ Tender
N ____ Numb H ____ Hypoesthesia
S ____ Spasm (loss of sensation)

Pain Index

(Least) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (Worst)

Gastro-Intestinal System
□ Poor appetite
□ Excessive hunger
□ Difficulty chewing
□ Difficulty swallowing
□ Excessive thirst
□ Nausea
□ Vomiting blood
□ Abdominal pain
□ Diarrhea
□ Constipation
□ Black stool
□ Bloody stool
□ Hemorrhoids
□ Liver trouble
□ Gall Bladder problems
□ Weight trouble

Nervous System
□ Numbness
□ Loss of feeling
□ Paralysis
□ Dizziness
□ Fainting
□ Headaches
□ Muscle jerking
□ Convulsions
□ Depression
□ Insomnia

Habits
□ Cigarettes
□ Alcohol abuse
□ Drug abuse
□ Coffee/ Tea
□ Other:
_____

Cardio-Vascular and Respiratory System
□ Chest pain
□ Pain over heart
□ Difficulty breathing
□ Persistent cough
□ Coughing phlegm
□ Coughing blood
□ Rapid heartbeat
□ Blood pressure problem
□ Heart problems
□ Lung problems
□ Varicose veins
□ Swollen ankles

Eye, Ear, Nose and Throat System
□ Eye strain
□ Eye inflammation
□ Vision Problems
□ Ear pain
□ Ear noises
□ Ear discharge
□ Hearing loss
□ Nose pain
□ Nose bleeding
□ Nose discharge
□ Difficulty breathing through nose
□ Sore gums
□ Dental problems
□ Sore mouth
□ Sore throat
□ Hoarseness
□ Difficult speech
□ Sinus problems
□ Allergies
□ Jaw pain

Past Health: Have you ever suffered from any of the following conditions?

□ Thyroid trouble
□ Diabetes
□ High blood pressure
□ Heart Disease
□ Allergies
□ Tuberculosis
□ Pneumonia
□ Back pain
□ Headaches
□ Stomach Ulcers
□ Emotional problems
□ Epileptic Seizures
□ Asthma
□ Arthritis
□ Alcoholism
□ Psoriasis
□ Polio
□ Cancer
□ Venereal Disease
□ HIV

Patient Signature: _____ Date: _____

Patient Accepted?: □ Yes □ No Doctor Signature: _____ Date: _____