Elkin Natural Health Centre

160 Brant Avenue, Brantford, Ontario N3T 3H7
Telephone (519) 751-1154 Fax: (519-752-8879

File #___________
Office use

Name:____ Marital Status: __________

Address: ____ Postal Code: ____________

How do you wish to be contacted? Home ☐ Office ☐ Cell ☐ Email ☐

Phone#: (H) _____________________ (W) _____________________ (C) _____________________

E-Mail ________________________________ Occupation ________________________________

S.I.N# ________________________________ Date of Birth _______________________________

Is this a Worker's Compensation Claim? _____ Medical Doctor _____________________________

CONGRATULATIONS ON YOUR DECISION TO BEGIN CHIROPRACTIC CARE. IN ORDER FOR US TO SERVE YOU BEST, PLEASE COMPLETE THE FOLLOWING:

Last Chiropractor __________________________ Date of Last Visit: ___________________________

What is the purpose of your decision to begin Chiropractor Care?

Pain Relief ☐ Stress Reduction ☐ Improved General Health and Well Being ☐

Improved Posture ☐ Spinal Correction ☐ Improved Physical and Mental Performance ☐

To improve a specific aspect of my health ☐ Details ______________________________________

Are other members of your family receiving Chiropractic care? Yes ___ No ___ N/A ___

Are you taking any medication? ___ If yes, what: ____

Were you ever a smoker? ___ From: __________ To: __________

Referred to our office by: __________________________________

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____

Check any of the following that you have experienced in the past, or are experiencing currently:

☐ Mood Swings / depression
☐ Anger / Loss of temper
☐ Chronic colds
☐ Allergies
☐ Sinus Problems
☐ Tension and / or migraine headaches
☐ Neck pain
☐ Asthma
☐ Numbing / tingling in arms or hands
☐ Carpal Tunnel Syndrome
☐ Shoulder pain
☐ Pain between shoulder blades
☐ Chest pain / Heart palpitations
☐ History of cancer or heart disease
☐ Low back pain
☐ Leg pain / Sciatica
☐ Digestive problems
☐ Females: Irregular Menstrual cycles
☐ Other female disorders
☐ Difficulty sleeping
☐ Fatigued / tired
☐ Skin Problems

Which of the above is the worst? __________________ How long have you had it? __________________

Which of the following is most affected when your health is at its worst?

- ☐ Work
- ☐ Home life
- ☐ Relationships (family, children, friends, co-workers)
- ☐ Spiritual relationships
- ☐ Hobbies
- ☐ Sleep
- ☐ Time with spouse or children
- ☐ Exercise / sports
- ☐ Attitude
- ☐ Energy levels

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, diagnostic x-rays, on me by the Doctor of Chiropractic and or anyone working in for 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 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 the risks and complications and 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, as in my interests. I have read the above consent. 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Patient's Name	Signature of Patient (or parent / Guardian)	Date signed