RIVER STONE
Massage & Wellness Centre

Date _____

CHIROPRACTIC

Confidential Patient Case History Form

Name: _____ ❒ Male ❒ Female

Address: _____ City: _____ Postal Code: _____

Email: _____ Age:____ Birthdate: (Day)_____ (Month)_____ (Year)_____

AB Health Care #: _____ Home Phone: _____ Cell Phone: _____

Medical Doctor: _____ Doctor Phone #: _____

Emergency Contact Name: _____ Phone #: _____

How did you hear about us? (check one below)

❒ Google Search ❒ Facebook ❒ Instagram ❒ Referral from: _____

❒ Convention/Event ❒ Door Hanger ❒ Flyer from: _____ ❒ Other: _____

I agree that River Stone Massage may notify me of new treatments and promotions via email. ❒ Yes ❒ No

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
❒ High blood pressure
❒ Low blood pressure
❒ Chronic congestive heart failure
❒ Heart attack
❒ Phlebitis / varicose veins
❒ Stroke / CVA
❒ Pacemaker or similar device
❒ Heart disease
❒ Dizziness / vertigo
❒ Seizures
❒ Blood clots

Is there a family history of any of the above? ❒Yes ❒No

Head and Neck
❒ History of headaches
❒ History of migraines
❒ Vision problems
❒ Vision loss
❒ Ear problems
❒ Hearing loss

Women
❒ Pregnancy
Due Date: _____
❒ Previous Pregnancy Complications:
Describe: _____
❒ Menopausal problems:
Describe: _____
❒ Menstrual problems:
Describe: _____
❒ Gynecological conditions
Describe: _____

Respiratory
❒ Asthma
❒ Bronchitis
❒ Emphysema
❒ Chronic Cough
❒ Shortness of breath

Is there a family history of any of the above? ❒ Yes ❒ No

Muscle/Joint
❒ Neck
❒ Back (❒ lower ❒ mid ❒ upper)
❒ Shoulders
❒ Elbow
❒ Wrist / Hand
❒ Hip
❒ Knee
❒ Ankle / Foot
❒ Spine

Infectious Conditions
❒ Skin Conditions
Describe: _____
❒ Respiratory Conditions
Describe: _____
❒ Hepatitis

Skin Conditions
❒ Eczema
❒ Psoriasis
❒ Rash
❒ Warts
❒ Open Sores

Digestive
❒ Constipation
❒ Crohn's Disease
❒ Colitis
❒ Irritable Bowel Syndrome
❒ Ulcers

Other
❒ Loss of sensation
Where? _____
❒ Diabetes
Onset: _____
Type: _____
❒ Allergies / hypersensitivity
What? _____
❒ Epilepsy
❒ Cancer
Type/Location: _____
❒ Arthritis
Type/Location: _____
❒ Hemophilia
❒ Fibromyalgia
❒ Chronic fatigue
❒ Scoliosis
❒ Polio / Post Polio
❒Osteoporosis

Is there a family history of any of the above? ❒ Yes ❒ No

Men
❒ Enlarged Prostate
❒ Libido Issues
❒ Other
_____

What is your occupation? _____

Do you have any medical conditions not listed above? ❒ Yes ❒ No

If yes, please describe: _____

_____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?

❒ Yes ❒ No *If yes, please describe:* _____

_____

<u>Please circle any area causing you symptoms of pain, stiffness, numbness or other forms of discomfort:</u>

Face	Upper Back	Arm(s)	Hand(s)	Thigh(s)	Ankle(s)	Neck
Elbow	Mid Back	Finger(s)	Knee(s)	Feet	Shoulder(s)	Wrist(s)
Hip(s)	Lower Back	Leg(s)	Toe(s)	Chest	Ribs	Tailbone

For what condition or reason are you seeking treatment today? _____

_____

Have you seen any other health care professional(s) for this condition or reason? ❒ Yes ❒ No

Have you ever been involved in a motor vehicle accident? ❒ Yes ❒ No Date:_____

Have you been involved in any other accidents? ❒ Yes ❒ No Date:_____

Have you ever been knocked unconscious? ❒ Yes ❒ No Date:_____

Have you ever had a work-related injury? ❒ Yes ❒ No Date:_____

Briefly explain any surgeries you have undergone, for what and when:

_____

_____

Have you had recent X-rays and if so what were the findings?

_____

_____

Are you presently taking any prescribed medication(s)? ❒ Yes ❒ No

If yes, please note the medication(s) and the condition(s) for which it is being used if known.

_____

_____

Have you previously received chiropractic treatment? ❒ Yes ❒ No

If yes, were you treated: ❒ At this clinic ❒ Other

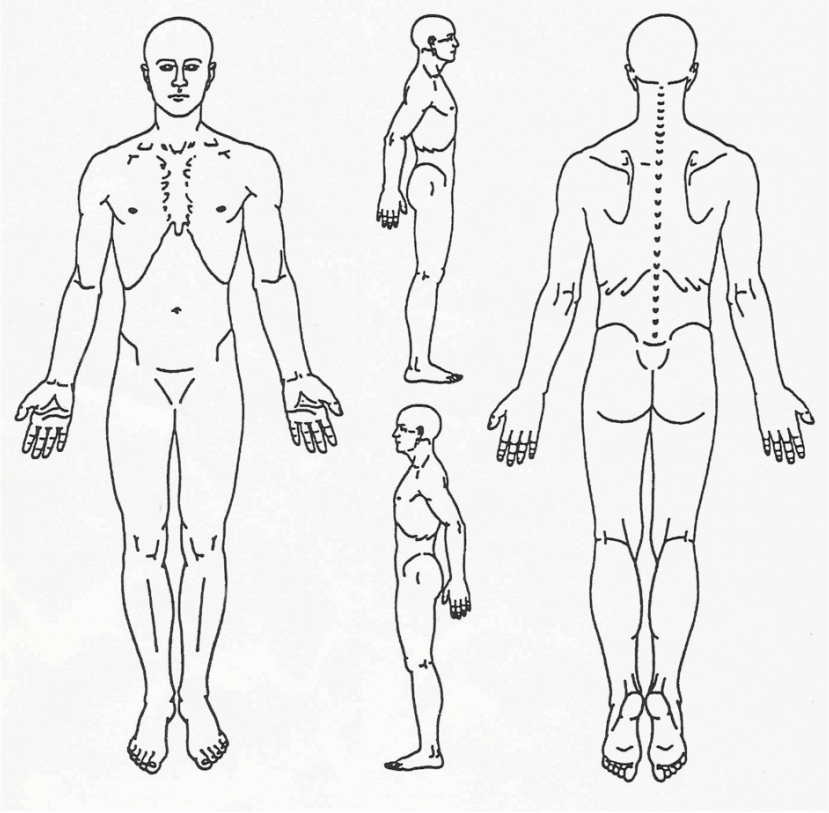
Have you ever had your neck adjusted? ❒ Yes ❒ No

Are, or were, you a smoker? ❒ Yes ❒ No

Please rank your stress levels? ❒ Low ❒ Medium ❒ High ❒ Very High

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Mark areas where pain radiates or spreads with arrows ↑, ↓, ←, → to indicate the direction of radiating pain. Include all affected areas.

A = Ache	B = Burning	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	O = Other



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

How long have you experienced this pain? ❒ **Years** ❒ **Months** ❒ **Weeks**

Is this your first episode of neck/pain? ❒ Yes ❒ No

I acknowledge that no assurance or guarantee has been provided as to the results of the treatment. I understand that the Chiropractor must be fully aware of my existing medical conditions. I have completed my medical history form as provided by River Stone and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Chiropractor updated on my medical history. I give consent for my treatment notes to be read by the other health care professionals at River Stone Massage. The information I have provided is true and complete to the best of my knowledge.

For insured clients:
I hereby consent to direct billing so that River Stone Massage and Wellness Centre may bill my health insurance company and have that company pay River Stone directly for my treatments. By signing this I also state that I will pay any outstanding fees for treatments received that are not covered by my insurance company.

Cancellation:
We require 24 hours' notice if you need to cancel/change your appointment so that we may accommodate another client in need of our therapeutic services. If you cancel with less than 24 hours' notice, a $30.00 cancellation fee will be charged to your account and/or credit card. We hold encrypted credit card information on our secure server.

_____	_____	_____
Signature	Date	Chiropractor Signature

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor