

# Anderson Chiropractic Group

300 Lakeshore Drive, Suite 102, Barrie, Ontario, L4N 0B4 (705) 734-9520



## ADULT HEALTH HISTORY FORM

### Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Patient # : \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birth date : \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Email address: \_\_\_\_\_  Please add me to your email list

Who may we thank for referring you? \_\_\_\_\_

Emergency Contact (name): \_\_\_\_\_ Phone: \_\_\_\_\_

### Current Health Concern

If there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box

Health Concern: \_\_\_\_\_

If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) 1 2 3 4 5 6 7 8 9 10

Circle or describe it's character: Sharp , dull, ache, burning, tingling, throbbing, spasm

When did you first notice it? \_\_\_\_\_

What happened? \_\_\_\_\_ How often does it occur? \_\_\_\_\_

What relieves it? \_\_\_\_\_ What aggravates it? \_\_\_\_\_

Does it radiate or cause problems somewhere else? \_\_\_\_\_

Any associated or related concerns? \_\_\_\_\_

Other professionals seen for this: \_\_\_\_\_ Treatment and results \_\_\_\_\_

Family doctor's name: \_\_\_\_\_ Recent tests done:  Bloodwork  Urine  xRays

### Other Health Concerns

Please note all other health concerns present or in the past. Please tick applicable boxes.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Blood Pressure hi/lo |
| <input type="checkbox"/> Blood Sugar hi/lo    | <input type="checkbox"/> Bleeding Disorder  | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Colds (frequent)     |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Fatigue              |
| <input type="checkbox"/> Fertility Challenges | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Lowered Resistance   |
| <input type="checkbox"/> Menstrual Pain       | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Numbness/Tingling    |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Pinched Nerve      | <input type="checkbox"/> Prostate Problem     |
| <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Thyroid Disorder     |

Other: \_\_\_\_\_

For women: Are you pregnant?  Yes  No  Unknown

### Physical Stresses

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File # \_\_\_\_\_

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Any significant injuries, falls or traumas during infancy or childhood?  Yes  No  Unsure

If yes please explain: \_\_\_\_\_

Any significant injuries, falls or traumas during adulthood?  Yes  No  Unsure

If yes please explain: \_\_\_\_\_

Any hospital visits?  Yes  No Have you had any surgeries, fractures, car accidents?  Yes  No

If yes please explain and list dates: \_\_\_\_\_

Are you in prolonged postures? (ie: repetitive work, lifting, sitting, driving)  Yes  No

If yes please explain: \_\_\_\_\_

Any hobbies that are physically strenuous or have repetitive movements?  Yes  No

If yes please explain: \_\_\_\_\_

What is your exercise level?  Low  Moderate  Heavy  1-3x/wk  4-7x/week

What do you do for exercise? \_\_\_\_\_

What position do you sleep in?  Back  Side  Stomach For how many hours? \_\_\_\_\_

Any fractured bones or dislocations? \_\_\_\_\_

## Chemical Stresses

Are you taking prescription or over-the-counter medications?  Yes  No

If yes please explain what you are taking & why: \_\_\_\_\_

Are you currently taking supplements?  Yes  No

If yes please explain what you are taking and why: \_\_\_\_\_

Do you smoke?  Yes  No  Quit If yes, how much: \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, approximately how much: \_\_\_\_\_

Are you happy with your diet?  Yes  No

Do you eat a specific diet? If so, what? \_\_\_\_\_

Are you exposed to pollutants, strong smells, chemicals, aerosols?  Yes  No  Occasionally

## Anderson Chiropractic Group Informed Consent

In order for the Doctor of Chiropractic indicated below to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may



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include a diagnostic radiographic examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by the Chiropractor indicated below, or any party authorized to do so by that Chiropractor. I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that there are, however, some risks associated with Chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

I understand that in rare cases there have been incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapist, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements such as coughing sneezing, turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to stroke. The risk of stroke after a cervical adjustment is estimated to be approximately 1 in 1 million. To put this in perspective, studies that have assessed the risk from interventions a non-chiropractor commonly uses for the same complaints have found the following:

Risk of paralysis or stroke from surgeries or neck pain	15,600 per 1 million
Risk of death from surgery for neck pain	6,900 per 1 million
Risk of serious GI event from a NSAID (eg. Aspirin, ibuprofen)	1,000 per million
Risk of stroke following a chiropractic adjustment	1 per 1 million

To put this further into perspective, these studies estimate the risk of death before the age of 35 due to smoking cigarettes is 1677 per 1 million, and annual risk for being injured in a car accident is 13,333 per 1 million.

Another complication that may arise following a spinal adjustment is a rib fracture, muscle strain, or ligament sprain. These complications are extremely remote and the Doctor of Chiropractic is trained to assess your spine and adjust in ways that significantly diminish the risk of this occurring.

I have read and understood the risks inherent in undergoing chiropractic care, although, I do not expect the Doctor to be able to anticipate and explain all of the risks that could possibly occur. I wish to rely on the Doctor to exercise judgment during the course of chiropractic care on that basis. I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

ANDERSON CHIROPRACTIC DOCTORS:  
DR. TOM RYAN D.C., DR. ANDREA RYAN D.C

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

## Anderson Chiropractic Group Fee Consent

### Initial Examination

Adult	\$ 99.00
Child/Student	\$ 89.00



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This fee includes cost of consultation, examination and report. Please allot one hour for this initial visit and thirty minutes for the report of findings

### Adjustments

Adult	\$ 39.00
Child/student	\$ 25.00

Progress Examination & Report \$20.00

Comparative Examination & Report \$50.00

You are responsible for the fees incurred for each visit at the time the services are rendered. If you have extended health care coverage, please check with your insurance carrier for the particulars of your coverage. It is the policy of this office for the patient/guardian to be responsible for taking care of their account and we will provide you with an itemized statement of the services rendered. We do not bill insurers directly on your behalf. We are also happy to provide you with itemized receipts for income tax purposes.

All new complaints or injuries are assessed as per a new patient with a history and examination to ensure we have the appropriate information to assist you.

Please sign below to indicate that you have read and understood the Investment Schedule. Should you have any questions, please ask front desk staff for further information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### E-nate Informed Consent

I provide consent to undergo treatment under the care of Dr. Tom Ryan D.C./ Dr. Andrea Ryan D.C. I understand that I will be asked to provide information about my progress throughout the treatment process, which will be added to my patient file. I am also aware that Dr. Tom Ryan D.C./ Dr. Andrea Ryan D.C. will be adding information regarding my treatment to my patient file with every clinical visit that occurs.

It has been explained to me that the information in my patient file will be accessible by myself on an online patient file, when this feature becomes available. I understand this information will allow me to track my own progress and allow me to have an effective form of communication with my Doctor of Chiropractic. I am aware of the benefits of such a system, as it provides my Doctor of Chiropractic with more concise data with which to best manage my care, and it therefore allows for more effective tracking of my therapeutic process.

Name: \_\_\_\_\_ Date \_\_\_\_\_

Signature: \_\_\_\_\_

### Mental/Emotional Stresses

As psychological stress has been shown to negatively affect nervous system function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being low stress, 10 being high stress.

Life in general I feel 1 2 3 4 5 6 7 8 9 10

Work and Career I feel 1 2 3 4 5 6 7 8 9 10

Relationships I feel 1 2 3 4 5 6 7 8 9 10

Time management I feel 1 2 3 4 5 6 7 8 9 10

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Quality of sleep I feel 1 2 3 4 5 6 7 8 9 10

Health/ well-being I feel 1 2 3 4 5 6 7 8 9 10

If you are experiencing significant or ongoing stress please explain

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## Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children.

- Cancer    Hypertension    Stroke    Arthritis    Autoimmune Disorder    Diabetes    Other
- 

## Why Are You Here?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Improvement in function | <input type="checkbox"/> Pain reduction     | <input type="checkbox"/> Improved quality of life    |
| <input type="checkbox"/> Wellness                | <input type="checkbox"/> Relief of Symptoms | <input type="checkbox"/> Healthier immune system     |
| <input type="checkbox"/> Stress reduction        | <input type="checkbox"/> Increased Mobility | <input type="checkbox"/> Clear Brain Body Connection |
| <input type="checkbox"/> Other: _____            |   |  |