Northoak Chiropractic neurology

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Patient Information

Today's Date (Month/Day/Year): _____/_____/_____ Date of Birth (Month/Day/Year): _____/_____/_____ Age:_____

Name:_____ Sex: M____ F ____ other _____

Address:_____

City:_____ Province:_____ Postal code:_____

Phone: (_____) _____ Cell: (_____) _____ Email: _____

Marital Status: Single _____ Divorced _____ Widowed _____ Married : Spouse's Name: _____

Work Status: Employed_____ Retired_____ Disabled _____ Student _____

Occupation: _____Employer: _____Employer Phone: _____

Name & Number of Emergency Contact: _____

Who referred you to our office? _____

Please list your 5 major health concerns in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

PATIENT HABITS

Sleep Cycle:

I go to bed at _____pm. I usually have difficulty falling asleep. Yes_____ No_____

I frequently wake up in the middle of the night, between 1-3 am. Yes_____ No_____

I typically wake up to start my day at _____am. and I usually feel: Well Rested _____ Tired _____ Exhausted._____

I snore. Yes _____ No _____

I had a sleep study performed and the doctor diagnosed me with sleep apnea. Yes_____ No_____

Sleep study performed: When_____ By Whom: _____

I use a sleep aid (C-PAP or medications) Yes_____ No _____

Eating Habits:

I typically eat breakfast at _____am and it usually consists of_____.

My morning routine does_____ does not _____ include coffee to "get the day started".

I have a morning snack at _____am and it consists of _____.

I eat lunch at _____ pm and it consists of _____

I have an after noon snack at _____pm and it consists of _____.

I eat dinner at _____pm and it consists of _____.

I have an evening snack at _____pm and it consists of _____.

I eat out _____times/week. I eat fish _____times/week. I eat raw nuts/seeds _____times/week.

Have you ever had a nutrition consultation? Yes _____ No _____

Have you made any changes in your eating habits because of your health? Yes _____ No_____

Describe: _____

Do you currently follow a special diet or nutritional program? Yes_____ No_____

Check all that apply:

Low Fat _ _ Low Carbohydrate_ _ High Protein_____ Low Sodium_____ Diabetic_____ Dairy-Free_ _

Soy-Free_ _ Gluten-Free_____ Vegetarian_____ Vegan_ _ Ultrametabolism_____ Organic _ _

Specific Program for Weight Loss/Maintenance Type: _____

Other _____

Daily Fluid Intake:

I typically consume _____glasses/bottles of water daily; _____cups of tea (black/green/herbal); _____cups of coffee (choose

One): decaf_____ regular _____ ____soft drinks ____ energy drinks; ____alcoholic beverages/week.

Daily Routine:

My occupational stress level is _____/10 (0= no stress and 10= severe stress) and my personal stress level is _____/10.

My occupation requires me to be "on the road" frequently Yes_ _ No_____

My exercise level is: Non existent_ _ Minimal (1--2days/wk)_____ Moderate_____ Intense (5+ days/week)_____

Type of Exercise : _____

Currently Smoking? Yes_____ No _____ How many years? _____ Packs per day: _____

Previous Smoking? How many years? _____ Packs per day? _____ Second Hand Smoke Exposure? _____

Supplements: Please list the supplements/vitamins you currently take :

Supplements		Dose	Frequency	Start date	Reason for use
1.					
2.					
3.					
4.					
5.					
6.					

Medications: Please list the **Prescribed and "over-the-counter"** medications you currently take:

Medications		Dose	Frequency	Start date	Reason for use
1.					
2.					
3.					
4.					
5.					
6.					

Have your medications or supplements ever caused you unusual side effects or problems? Yes_____ No_____

Describe: _____

Have you had prolonged or regular use of: NSAIDS (Advil, Aleve, Motrin, Aspirin, etc)_____ Tylenol_____ Allergy shots_____

Acid Blocking Drugs (Tagamet, Zantac, Prilosec)_____ Antibiotics > 3 times/year _____

Corticosteroids (prednisone, nasal inhalers)_____ Oral Contraceptives_____

Do you use creams or lotions of any kind? Facial/Eye_____ Revitalizing_____ Hormonal_____

Medical History:

Have you benefitted from previous Chiropractic Care? Y_ _ N _____ When were you last adjusted?_____

Who is your family physician?_____

May we send OUR REPORT to your doctor? Yes_____ No_____

Medical Tests and Date: *Check box if yes and provide date:*

☐ Physical Exam _____	☐ Blood testing _____	☐ Urine test _____
☐ Bone Density _____	☐ Colonoscopy _____	☐ Cardiac stress test _____
☐ EKG _____	☐ Stool test _____	☐ MRI _____
☐ CT Scan _____	☐ X-rays _____	☐ Upper endoscopy _____
☐ Upper GI series _____	☐ Ultrasound _____	☐ Salivary Hormones _____

Please list any and all surgeries you have had with approximate date:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list your significant infections, traumas and accidents:

1. _____ 3. _____
2. _____ 4. _____

SELF AND FAMILY MEDICAL HISTORY:

Check all that apply	**Self**	Mother	Father	Brother	Sister	Children	Mothers Parents	Fathers Parents
Current Age						N/A	N/A	N/A
Cancer								
Heart Disease								
Hypertension								
Diabetes								
Hypoglycemia								
Insulin resistance								
Obesity								
High Cholesterol								
Gout								

SELF AND FAMILY MEDICAL HISTORY continued:

Check all that apply:	**Self**	Mother	Father	Brother	Sister	Children	Mothers Parents	Fathers Parents
Stroke								
Inflammatory Arthritis (Rheumatoid, Psoriatic)								
Inflammatory Bowel Disease								
Celiac Disease								
Autoimmune Disease Lupus, Thyroid, Vitiligo								
Multiple Sclerocis								
Thyroid Disorder								
Asthma								
Food Allergies								
Environmental Allergies								
Psoriasis / Eczema								
Parkinsons or other tremor								
Lou Gehrig's or ALS								
Dementia								
Depression								
Bipolar								
ADD/ADHD								
Autism								
Substance Abuse								
Genetic Disorder								
Scoliosis								
Seizures								
Eating disorder								
Irritable Bowel Syndrome								
Other: _____								

Obstetric History *(FOR WOMEN ONLY) - Check box if yes and provide number*

Are you pregnant? Yes_____ No_____ How many weeks? _____

Pregnancies_____ Caesarean_____ Miscarriages _____ Abortion_____

Toxemia _____ Gestational Diabetes _____ Post Partum Depression _____

Are you currently breast feeding? Yes_____ No_____ For how long?_____

Age at First Period:_____ Menses Frequency:_____ Length:_____

Use of ***hormonal*** contraception such as: Birth Control Pills_____ Patch_____ NuvaRing_____ How long?_____

Women's Disorders – Hormonal Imbalances

Fibrocystic Breasts_____ Endometriosis_____ Fibroids_____ Infertility_____ Painful Periods_____ Heavy periods_____

PMS_____

Last Bone Density:_____ Results: High_____ Low_____ Within Normal Range_____

Are you in menopause? Yes_____ No_____ Are you on hormone replacement? Yes_ _ No_____

Do you suffer any of these menopausal symptoms? Hot Flashes_____ Mood Swings_ _ Vaginal Dryness_____

Concentration/Memory Problems_____ Decreased Libido_____ Loss of Control of Urine_____

Male Disorders **HISTORY** *(FOR MEN ONLY)*

Date of your last PSA test _____ PSA Level: 0-2_____ 2-4_____ 4-10_ _ >10_ _.

Have you had any of the following in the last year? Prostate Enlargement_____ Prostate infection_____ Prostate cancer _____

Prostate "shots" (i.e.: Eligard)_ _ Change in Libido_____ Difficulty obtaining or maintaining an erection_____

Decreased Frequency of morning erections_____ Enlarged breasts_____ Fluid discharge from nipples_____

Nocturia (urination at night)_ _ Urgency/Hesitancy/Change in Urinary Stream_____ Loss of Control of Urine_____

Environmental & Detoxification Assessment

Do you have known adverse food reactions or sensitivities? Yes_____ No_____

If yes, describe symptoms:_____

Do you have any specific food allergies or sensitivities? Yes_____ No_____

If yes, list all:_____

Do you have an adverse reaction to caffeine? Yes_____ No_____

When you drink caffeine do you feel: Irritable or wired_____ Aches & Pains_____

Do you adversely react to (*Check all that apply):*

Monosodium glutamate (MSG)_____ Aspartame (NutraSweet)_____ Caffeine_____ Bananas_____ Garlic_____ Onion_____

Cheese_____ Citrus_ _ Chocolate_ _ Alcohol/Red Wine_ _ Sulfites (wine, dried fruit, salad bars)_____

Preservatives (ex. sodium benzoate)_____ Other: _____

Which of these significantly affect you? (*Check all that apply):*

Cigarette Smoke_____ Perfumes/Colognes_____ Auto Exhaust Fumes_____ Other: _____

In your work or home environment, are you exposed to: Chemicals_____ Electromagnetic Radiation_____ Mold_____

Have you ever turned yellow (jaundiced)? Yes _____ No _____

Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes_ _ No_____

Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as:

Herbicides_____ Insecticides_____ Pesticides_____ Organic Solvents_____ Heavy Metals_____

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? Yes_____ No_____

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I, (Patient Name) _____, here by authorize (Doctor/Clinic/Hospital name)_____ to disclose the following protected health information (including, but not limited to: patient notes, narratives, examinations and findings, laboratory work, radio logical studies, etc.) to Northoak Chiropractic .

I specifically authorize the release of data and information relating to: (mark the appropriate box)

Substance abuse

Mental Health (includes psychological testing)

HIV-related Information

This protected health information may be used or disclosed to carry out treatment, payment and/or health care operation at Northoak Chiropractic. This authorization shall be in force and effect as long as copies may reside in my patient records at Northoak Chiropractic or until records necessitate return.
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification. I understand that a revocation is not effective to the extent that Northoak Chiropratic has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or provincial law.
Northoak Chiropractic will not condition my: treatment; payment in a health plan; or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to refuse to sign this authorization.

_____Date_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of
optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____
Print Name Signature Date

Consent to Evaluate and Adjust a Minor Child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____ _____
Print Name Signature Date

Pregnancy Release

This is to certify that , to the best of my knowledge, **I am not pregnant** and the above doctor and his/her associates have my permission to perform an x-ray evaluation. **I have been advised that x-ray can be hazardous to an unborn child.**

Date of last menstrual cycle: _____

_____ _____ _____
Print Name Signature Date