ONE LIFE FAMILY Chiropractic
Love it, Live it

Application for Care at One Life Family Chiropractic

Name: _____ Date of Birth (dd/mm/yy): _____

Mailing address: _____

Apt # _____ City: _____ Prov: _____

Phone: h) _____ c) _____ Email: _____

Do we have your permission to send you your receipts, health updates and newsletters via email? Yes / No
*You can withdraw your consent at any time, however, we do our best to save trees.

Gender: **M** **F** Marital Status: _____ Spouse's name: _____

Do you have any children? Yes / No
Names and ages of children: _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Thank you for choosing One Life Family Chiropractic. We want to assure you that we will provide you with the best in Chiropractic service and recommendations in the most professional and honest manner.

In order to do this we will be conducting a Chiropractic analysis of your spine and nerve system. This may include some non-invasive procedures that are not familiar to you. The doctor will not perform any part of the analysis without your consent. Kindly, ask if you have any questions.

Once our analysis is complete we present our recommendations to you. This will require some basic knowledge that may be new to you even if you have been to Chiropractors in the past. Remember that our findings are strictly Chiropractic in nature and do not involve any other areas of your health.

We would like to begin this process with some information about you.

Please answer the following questions to the best of your ability.

Reason for consulting our office (please check only one):

1) ___ I have no special problem, I wish to use Chiropractic to help me try to live my life at my full potential.
2) ___ I have the symptom of a physical problem and I want to see if Chiropractic will enable my body to work better. I am also interested in learning about the role of Chiropractic in improving my overall health, and the health of my family.
3) ___ I have a symptom and I am only interested in relief.

Health History

Do you have any present complaints or health challenges? Explain:

_____

_____

When did this begin? _____

Have you had this problem before? _____

What is this interfering with in your life? _____

_____

Have you seen anyone for this complaint? If so, who and how did they manage your complaint?

_____

_____

Have you experienced any of the following?

__ Dizziness __ Night Pain __ Nausea __Numbness __Double Vision
__ Problem swallowing/speaking __ Fever __ a history of cancer
__ Bowel/Bladder difficulty __ Night Sweats __ Abdominal Pain

Please explain: _____

Past Health HIstory

Who is your family physician? _____

Have you seen your family physician in the past year? Yes / No

Why? _____

Date of your last physical exam? _____ (dd/mm/yyyy)

Are you pregnant? Yes / No

Have you had any surgeries? Include the year(s): _____

_____

Have you had any traumas, accidents, falls or injuries in the past year? _____

_____

Have you ever been diagnosed with a serious disease or condition? _____

_____

Chemical Stress and Challenges

List any prescription and non-prescription drugs.

Drug:	Purpose:
_____	_____
_____	_____
_____	_____

Are you a smoker (or use tobacco)?: Y / N

How much & how long?:_____

Emotional Stress and Challenges

List any emotional/mental stressors presently in your life and previous stressors:

_____

_____

_____

How would you rate your current emotional state?

Excellent Good Poor Other _____

General Health History

How would you rate the following?

Nutrition/Diet	Excellent	Good	Poor
Rest	Excellent	Good	Poor
Exercise	Excellent	Good	Poor

Have you been to a Chiropractor? Yes / No

If yes, how long ago? _____

Are you healthier than you were 5 years ago? _____

Do you believe you will be healthier in 5 years? _____

I, _____ (name) state that the above information is true to the best of my knowledge.

_____ _____(dd/mm/yy)

Signature Date

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to receive chiropractic adjustments and other chiropractic procedures (if necessary), from the doctors of chiropractic in this office.

I have had an opportunity to discuss with the doctors of chiropractic in this clinic the nature and purpose of chiropractic adjustments and care. I understand that results are not guaranteed.

I further understand and am informed that, as with all health care, there are some risks and possible risks associated with techniques used by a doctor of chiropractic. In particular please note:

a) While rare, some people may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual care techniques used. Although uncommon, rib fractures have also been known to occur following certain manual care procedures;

b) There are reported cases of stroke associated with visits to medical doctors and doctors of chiropractic. Research and scientific evidence does not establish a cause and effect relationship between chiropractic care and the occurrence of stroke. Recent studies suggest that a person may be consulting medical doctors and doctors of chiropractic when they are in the early stages of a stroke. In essense, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuiries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic care.

I do not expect the doctor to be able to anticipate and explain all risks and complications. During the course of my care, I wish to rely on the doctor to exercise judgement in my best interest, based upon the facts known at the time.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic care in general, (including the spinal adjustment), the different care options and recommendations available to me, and the contents of this Consent.

I consent to the chiropractic care recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.
Dated this _____ day of _____, 20___.

_____	_____
Print patient's full name	**Patient's (or guardian's) signature**
_____	_____
Name of witness	**Witness of signature**