M & Y Chiropractic Health and Wellness Centre
Confidential Health History Form for Complete Health Analysis

Date: ________________________

Last Name: _____________________________________ First Name: ______________________________ M / F

Address: ________________________________ City: _________________ Postal Code: __________________

Phone# (H): _______________________ (W): _______________________ (C): __________________________

D.O.B. ______/______/_______ Email Address: ____
day month year

Occupation: ____ Employer: _____________________________

Marital Status: Single ______ Married ______ Divorced ______ Separated ______ Widowed ______ Other ______

Emergency Contact Name: ________________________________ Relation: _______________________________

Phone#: ______________________________

How were you referred to our clinic? ____
(person's name, phone book, signs, etc…)

	NAME:	**ADDRESS:**	**PHONE #:**
Current Chiropractor:			
Current Massage Therapist:			
Current Naturopath:			
Current Medical Doctor:			

* *

Your Current Health Concerns

What is your main reason for coming in today? ____

____

List in order of importance other health concerns that are troubling you:

1) ____ How long? _______________________
2) ____ How long? _______________________
3) ____ How long? _______________________
4) ____ How long? _______________________

What kind of conventional treatment have you received? ____

____

What would you like to accomplish with our treatments? ____

____

How long has it been since you really felt good? ____

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Please list the medications you presently take: _____

_____

Please list the vitamins / supplements you presently take: _____

_____

Please list any known allergies: _____

Your Health History

What is the general state of your health? **Excellent_____ Good_____ Average_____ Fair_____ Poor_____**

Are you pregnant? Yes ☐ No ☐ Due date _____

What is your current level of energy from 1 to 10 (where 10 is the best you have ever felt)? _____

What is your current approximate weight? _____One year ago? _____ Ideal weight? _____ Height? _____

Please list the 5 most significant stressful events in your life:

1)_____ Date: _____

2)_____ Date: _____

3)_____ Date: _____

4)_____ Date: _____

5)_____ Date: _____

Are any of these situations continuing to impact your life? **Yes / No** *(If yes, please circle number.)*

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist?_____ Have you in the past?_____When?_____

Have you had any major injuries? If so, what happened and when? _____

_____

_____

_____

Previous surgeries and hospitalizations (include dates): _____

_____

_____

_____

How stressed are you? (**0** = no stress…….. **10** = nervous breakdown) **0** 1 2 3 4 5 6 7 8 9 **10**

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Please check the following conditions that apply to you. ***O*** – Occasionally ***F*** – Frequently ***C*** – Constantly

GENERAL

O F C

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Confusion
☐ ☐ ☐ Depression
☐ ☐ ☐ Difficulty concentrating
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Forgetfulness
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Headaches/migraines
☐ ☐ ☐ Hernia
☐ ☐ ☐ Loss of balance
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness
☐ ☐ ☐ Painful tailbone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Swollen joints
☐ ☐ ☐ Tremors
Other: _____

EYES, EARS, NOSE & THROAT

☐ ☐ ☐ Dryness
☐ ☐ ☐ Ear infections
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Glasses/contacts
☐ ☐ ☐ Loss of taste
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Repetitive colds
☐ ☐ ☐ Ringing in ears
☐ ☐ ☐ Sinus problems
Other: _____

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Bladder infection
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control bladder
☐ ☐ ☐ Kidney infection/stones
☐ ☐ ☐ Painful/burning urination
☐ ☐ ☐ Prostate problems
Other: _____

CIRCULATORY/RESPITORY

O F C

☐ ☐ ☐ Anemia
☐ ☐ ☐ Arrhythmia
☐ ☐ ☐ Asthma
☐ ☐ ☐ Bronchitis
☐ ☐ ☐ Blood clots
☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Cold feet/hands
☐ ☐ ☐ Cold sweats
☐ ☐ ☐ Difficulty breathing
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Night sweats
☐ ☐ ☐ Pain over heart/angina
☐ ☐ ☐ Palpitations
☐ ☐ ☐ Swelling of ankles
☐ ☐ ☐ Varicose veins
☐ ☐ ☐ Wheezing
Other: _____

SKIN

☐ ☐ ☐ Acne
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Change in mole
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives
☐ ☐ ☐ Itching
☐ ☐ ☐ Rashes
☐ ☐ ☐ Warts
Other: _____

FOR WOMEN ONLY

☐ ☐ ☐ Breast tenderness
☐ ☐ ☐ Excessive flow
☐ ☐ ☐ Fertility concerns
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ PMS
☐ ☐ ☐ Vaginal discharge
☐ ☐ ☐ Vaginal itching
Other: _____

DIGESTIVE

O F C

☐ ☐ ☐ Abdominal bloating
☐ ☐ ☐ Abdominal pain
☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Heartburn
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting blood
☐ ☐ ☐ Poor appetite
Other: _____

MUSCLE & JOINT

☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Neck pain/stiffness
☐ ☐ ☐ Pain btwn shoulders
Other: _____

PAIN OR NUMBNESS IN

☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Feet
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Jaw
☐ ☐ ☐ Knees
☐ ☐ ☐ Legs
☐ ☐ ☐ Shoulders
Other: _____

CARDIO VASCULAR

☐ ☐ ☐ CCHF
☐ ☐ ☐ Phlebitis

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PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ Abuse
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Aneurism
- ☐ Appendicitis
- ☐ Arthritis

Type: _____

- ☐ Cancer

Type: _____

- ☐ Cataracts
- ☐ Celiac disease
- ☐ Chorea
- ☐ Cosmetic surgery
- ☐ Crohn's disease
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Diverticulitis
- ☐ Eating disorder
- ☐ Eczema
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Hardening of the arteries
- ☐ Hearing impaired
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Herpes/shingles
- ☐ Influenza
- ☐ Irritable bowel syndrome
- ☐ Lupus
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Scarlet fever
- ☐ Scoliosis
- ☐ Sjogren's
- ☐ Spinal cord injury
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Venereal disease
- ☐ Vertigo
- ☐ Whooping cough

Are there any of these from which you feel you have been never well since? _____

DATE OF LAST:	6 mths	6-18	18+	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest x-ray	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Tea	☐	☐	☐	☐
Laxatives	☐	☐	☐	☐
Hormones	☐	☐	☐	☐

Personal Habits

What do you enjoy most in your life? _____

What are your main interests or hobbies? _____

What do you worry about most in your life? _____

What nurtures you? _____

Do you exercise? **Yes / No** *If yes, what do you do and how often?*_____

_____

Do you have a religious or spiritual practice? **Yes / No**

On a scale of 1-10, how would you rate the quality of your sleep (10 being great)_____

Do you have a problem falling asleep?____ Staying asleep?____ How much do you sleep?_____hours

How many hours do you think you need?_____ Do you wake refreshed?_____

Do you nap or rest horizontally throughout the day? **Yes / No** For how long?_____

How is your body temperature, compared to others? Warmer Cooler Average

Do you enjoy your work? **Yes/No** Do you take vacations? **Yes/No**

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How often do you get colds, flus, sore throats in a year? _____

Family History

	Mother	Father	Sibling	Grandparent		Mother	Father	Sibling	Grandparent
Cancer					Kidney Disease				
Tuberculosis					Diabetes				
Heart Disease					Asthma				
Stroke					Depression				
High Blood Pressure					Other: _____				

Occupational/Household

Is your home damp or moldy at all? **Yes/No** Do you have a specialized air filtration at home? **Yes/No**
Do you work in an office building? **Yes/No** Do the windows open? **Yes/No**
Do you work in the presence of toxic fumes or chemicals? **Yes / No**
Do any of your hobbies involve toxic materials? **Yes / No**
Are you currently exposed to second hand smoke? **Yes / No**
What do you use for drinking water? *(Circle)* **Tap Water Bottled Water Filtered Water Rev. Osmosis**

Is there anything else you feel I should know about you? _____

_____

Please list any additional comments regarding your health and well being: _____

_____

In order to help us to better understand your health care needs and requirements please answer the following:

Committing to changes in my health is _____

_____

What happens when you are not being accountable? _____

_____

How do you want to be supported in your health care needs? _____

_____

I hereby agree that all information is correct to the best of my knowledge and I hereby authorize, instruct and allow you to share any and all of my information found on these attached sheets and accumulated during the course of my treatment with any one or all of the practitioners involved in my health care at this clinic.

Print name_____ Signature_____

Date_____ Witness_____

THANK YOU FOR TAKING THE TIME TO FILL IN THIS LENGTHY QUESTIONNAIRE - IT IS A VALUABLE RESOURCE IN UNDERSTANDING YOUR HEALTH.

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

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

b) There have been reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

c) There are rare reported cases of disc injuries following manual cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor, including spinal adjustment.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____day of_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness Signature**

_____ _____

Patient Name (please print) **Witness Name** (please print)

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INFORMED CONSENT TO NATUROPATHIC TREATMENT

Naturopathic medicine is a unique approach to improving health and treating illness. Focusing on prevention, and using natural substances and treatments, Naturopathic Doctors support and stimulate the body's ability to heal itself. The methods used in this clinic for assessment include case history taking, physical examination and laboratory testing. Therapeutics include nutrition, homeopathy, botanical (herbal) medicine, physical medicine, hydrotherapy, detoxification techniques, acupuncture, hypnosis, craniosacral therapy and lifestyle counseling.
Each person must sign this document before any treatment will be rendered.
My signature acknowledges that I have been informed and understand that:

(1) I am encouraged to create a comprehensive health care team working towards my best interests and continue to seek medical care from other health care practitioners qualified to practice in Ontario such as a physician, surgeon, dentist, chiropractor, etc., as required.

(2) I understand that Naturopathic Doctors are required by their licensing boards to perform a screening physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is accepted by the attending practitioner.

(3) I have received a full and complete explanation of the treatments or services that I may receive at this office and hereby authorize and consent to treatment.

(4) I understand that working with a Naturopathic Doctor involves a team-like approach and while I expect my Naturopathic Doctor to provide me with appropriate individualized advice as to how to attain my wellness goals, I also commit to being responsible for my own health. If I am having difficulty following a treatment plan that I have agreed to, I will contact my Naturopathic Doctor so that we can make whatever modifications are necessary for my lifestyle to ensure that I continue to work towards my goal of wellness at whatever pace we decide on together.

(5) I agree to pay my full account at the time of each visit or treatment, including fees for services and costs of supplements, reference materials and laboratory tests. I am aware that these fees are not covered by OHIP. In the event that an invoice is not paid in a timely manner, I understand that 2% per month interest will be added to any outstanding balances.

(6) I am aware that I can purchase the products recommended by my Naturopathic Doctor at the location of my choice. I am under no obligation to purchase products at M&Y Chiropractic Health & Wellness Centre.

(7) I understand that to provide me with Naturopathic goods and services, M&Y Chiropractic Health & Wellness Centre must collect and use some personal information about me as required by law and governing bodies. Any other use of any personal information will require my express written consent.

(8) I understand that payment is due at the requested appointment time. I understand that M&Y Chiropractic Health & Wellness Centre requires a minimum of 24 HOURS NOTICE of any appointment change or cancellation. If I do not give 24 hour notice or fail to appear for my requested appointment time, I agree to pay the full fee for my appointment. I understand that this time is reserved for me. Initials_____

I, _____, have read, understood and acknowledge the above statements.

Signature of Patient: _____ Date: _____

Signature of Primary ND: _____ Date: _____

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INFORMED CONSENT TO ALTERNATIVE THERAPIES TREATMENT

I _____ agree to participate in the health services with the understanding that the counseling and the treatment/care provided are for my own lifestyle guidance, education and/or relaxation. I acknowledge that the service(s) of any one, and/or all of the following: ALD Massage, Reflexology, Reiki , Subtle Aromatherapy, Chakra Balancing and/or any other modality that I participate in, are not intended for the purpose of diagnosing or treating a specific ailment.

I acknowledge that should I take the advice/suggestion(s) given by the practitioner, it is my responsibility to check with my own medical doctor before commencing.

I attest that the information I have provided is true and complete to the best of my knowledge. I also understand that the information I have provided is confidential and will not be released without my consent.

I acknowledge that the practitioner is not a licensed medical doctor or medical practitioner and I therefore take full responsibility and release the practitioner from liability with respect to any advice of treatment/care which I may follow of my own free will.

I acknowledge that by signing this disclaimer once, it will cover all subsequent visits within one calendar year.

Signature _____ Date: _____

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INFORMED CONSENT FOR REGISTERED MASSAGE THERAPY

Please read carefully, and sign.

An accurate health history is important to assist in treating you safely. Feel free to ask any questions about the information being requested. If your health status changes in the future, please let us know.

I attest that the information I have provided is true and complete to the best of my knowledge. I also understand that the information on this form is confidential and will not be released without my written consent, unless allowed or required by law. I will be asked to provide written authorization for release of any information.

I acknowledge that I am responsible for any charges incurred in the course of my treatment and understand that a minimum of 24 hours notice is required to reschedule or cancel any appointment or a charge of the full fee plus HST for the appointment time booked will apply.

Massage Therapy is most fully experienced without clothing. However, if you are uncomfortable with this, it is totally up to your discretion and comfort, what you leave on. You will be covered completely with a sheet except for the area that is being worked on. All massages are **strictly therapeutic and non-sexual**. If any area that is being worked on is uncomfortable, you have the right to change your mind and ask the therapist to stop. ***Good communication is the key for your therapist in working within your comfort zone.***

I, as the client have the right to stop, clarify and ask questions about the massage. I also have the right to discontinue treatment at any time. I understand that the information I have provided on this form will remain confidential and will be used for no other purpose than the professional therapist's records.

I also understand that it is the therapist's right to discontinue treatment at any time and for any reason.

Signature: _____ Date: _____

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OFFICE POLICIES FOR PATIENTS

It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

UPON ARRIVAL

Please remove your shoes and check in at front desk. Fill out any necessary forms and return them to front desk. One of our health team members will escort or direct you to your adjusting or treatment room.

Chiropractic – Once you are in an adjustment room please empty your pockets (keys, wallet etc.) and remove any earrings and long necklaces. **Please lie face down on the table as this will relax your muscles and take the stress of gravity off your spine thus facilitating a more comfortable adjustment.**

Registered Massage Therapy, Naturopathic Medicine and Alternative Therapies – Once in your treatment room your practitioner will discuss treatments for the session. This may include areas to be treated, your position on the table, benefits/risks, today's goals and a verbal consent will be obtained before the treatment commences. If you want to change or refuse any part of the treatment at any time you have the right to do so. Your practitioner will then leave the room so that you may undress if necessary and re-enter the room once you are ready. You are covered with sheets at all times; only the area being worked on will be uncovered.
After the treatment your practitioner will suggest a treatment schedule to best suit your individual situation. They may also recommend after care exercises or stretching to further enhance your treatments. You may be asked to complete some paperwork between your treatments to allow your practitioner to fully understand the nature of your issues. Those who follow these recommendations notice better and longer lasting results.

YOUR SCHEDULE

Your specific course of care has been designed just for you by your Health Care Provider and your appointment time has been set aside specifically for you. The importance of keeping your appointments and being on time is crucial to help make our office as efficient as possible for the benefit of all our patients. If you do need to reschedule an appointment we require a minimum of 24 hours notice. Any missed appointments or cancellations without adequate notice may result in a fee being charged to you. Due to the healing nature of your treatments, we request that any missed or cancelled sessions be made up at the earliest available time, ideally within 24 hours. Please understand that as a patient you are responsible for any and all charges incurred during the course of your treatment at our wellness centre. When seeing multiple health team members we will do our best to align your appointments together because we value your time as well. If requested, a personal appointment calendar can be supplied to you.

REFERRALS

Once you understand the importance and benefits provided by each of our Health Care Providers, we are confident that you will want everyone in your family checked. The nicest compliment you can give our clinic is to refer us to your family and friends. Please feel free to ask anyone on our health team for any literature you may require.

Welcome to our Health and Wellness Family.

I agree and understand the above policies. Signed_____

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