Dr Darren Poncelet, B.Sc., D.C.
M & Y Chiropractic Health and Wellness Centre
Confidential Health History Form

Date: _________________________

Last Name: ______________________________________ First Name: _______________________________ M / F

Address: _________________________________ City: __________________ Postal Code: __________________

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

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

Emergency Contact Name: _________________________________ Phone#:________________________________

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

* *

Reason for your visit today? ____

What would you like to accomplish with our treatments? ____

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

Are you under medical/therapeutic care? ☐ yes ☐ no For what condition? _______________________________

Previous Traumas, Operations and Diagnosed Medical Conditions: ____________________________________

____

Medications you presently take: ____

Vitamins / Supplements you presently take: ____

Please list any known allergies: ____

Height: ________Weight: ________ Blood Pressure: __________ Pregnant? yes ☐ no ☐ Due Date:__________

Do you sleep well? ☐ yes ☐ no What position do you sleep in?____

Regular exercise? ☐ yes ☐ no Type of exercise / frequency:____

Do you wear orthotics (custom arch supports)? yes ☐ no ☐

Occupation: _________________________ Activities: ____

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

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

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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: __________________

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PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ AIDS/HIV
☐ Alcoholism
☐ Aneurism
☐ Appendicitis
☐ Arthritis
Type: _______________
☐ Cancer
Type: _______________

☐ Diphtheria
☐ Diverticulitis
☐ Eating disorder
☐ Eczema
☐ Emphysema
☐ Endometriosis
☐ Epilepsy
☐ Fever blisters

☐ Heart Attack
☐ Hepatitis
☐ Herpes/shingles
☐ Influenza
☐ Irritable bowel syndrome
☐ Lupus
☐ Malaria
☐ Measles

☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Rubella
☐ Scarlet fever
☐ Scoliosis
☐ Sjogren's
☐ Spinal cord Injury

☐ Cataracts
☐ Celiac disease
☐ Chorea

☐ Fibromayalgia
☐ Glaucoma
☐ Goiter

☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps

☐ Stroke
☐ Tuberculosis
☐ Typhoid fever

☐ Cosmetic surgery
☐ Crohn's disease
☐ Diabetes

☐ Gout
☐ Hardening of the arteries
☐ Hearing impaired

☐ Osteoporosis
☐ Pacemaker
☐ Pleurisy

☐ Venereal disease
☐ Vertigo
☐ Whooping cough

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	☐	☐	☐	☐

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; this information about your family members will give us a better picture of your total health.)

NAME:	AGE:	RELATION:	PAST & PRESENT HEALTH PROBLEMS:

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

____

____

____

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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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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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Consent to Collect and Release Information

I_______________________________, or my appointed representative______________________________
Print   Print

Consent for *M&Y Chiropractic Health and Wellness Centre* to collect and release my general patient medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.
In terms of information, *M&Y Chiropractic Health and Wellness Centre* may collect any of the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergency or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How your Information Will Be Used
Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist 3rd party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to Information
I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings

Acknowledgment
I allow for medical personnel to use and disclose my information as outlined above.
I understand that I can access my personal health information as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions:
____
____
____

□ Consent □ Do not Consent

Patient signature:_________________________________Date:___________________________________

Witnessed:______________________________________Date:____________________________________

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