

# Momentum Health Patient Intake Form

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: MMM / DD / YYYY AGE: \_\_\_\_\_ BC HEALTH CARE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

CITY: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ May we contact you by email? YES or NO

Would you like to be set up for appointment reminders? YES - Email / Text / Both or NO Reminders

OCCUPATION: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR CLINIC? (please circle one)**

Website Doctor (name: \_\_\_\_\_) Patient/Friend (name: \_\_\_\_\_) Walk-in  
Other: \_\_\_\_\_

**Do we have your permission to contact your family physician regarding coordination of your care? YES or NO**

If yes, what is your family doctors name and location of practice? \_\_\_\_\_

**PLEASE NOTE OUR LATE CANCELLATION/MISSED APPOINTMENT POLICY:**

Momentum Health is committed to providing all of our patients with exceptional and timely care. We would appreciate 24 hours advance notice if you are unable to attend a scheduled appointment so we can attempt to fill the appointment time. Failure to do so may result in a **\$50 missed appointment charge** payable prior to your next appointment being administered to your account.

I have read and agree to the above terms: \_\_\_\_\_ (Initial)

**Is the reason you came to this office related to a:**

- |                               |     |    |                                     |
|-------------------------------|-----|----|-------------------------------------|
| A) Motor Vehicle Accident?    | YES | NO | Date of loss: <u>MM / DD / YYYY</u> |
| B) Work-related injury (WCB)? | YES | NO | Date of loss: <u>MM / DD / YYYY</u> |

**When did your symptoms start?** \_\_\_\_\_

**Describe your symptoms and when they began:** \_\_\_\_\_

**How often do you experience your symptoms?**

- Constantly (76 - 100% of the day)
- Frequently (51 - 75% of the day)
- Occasionally (26 - 50% of the day)
- Intermittently (0 - 25% of the day)

**What describes the nature of your symptoms?**

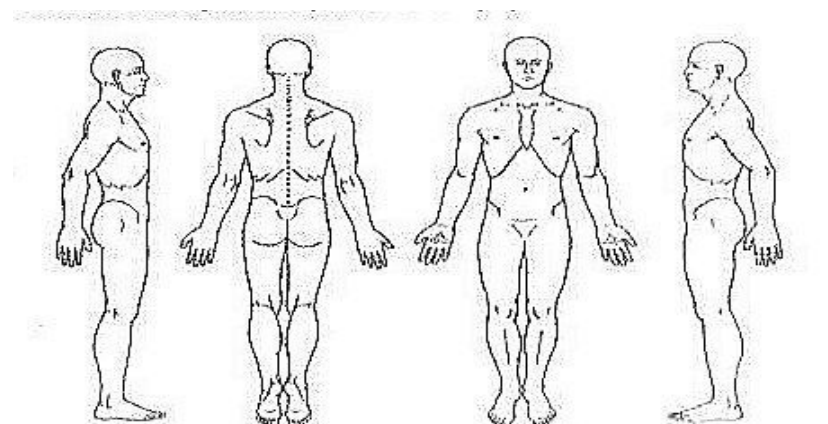
- |                                    |                                   |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp     | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Dull ache | <input type="checkbox"/> Burning  |
| <input type="checkbox"/> Numb      | <input type="checkbox"/> Tingling |

**How are your symptoms changing?**

- Getting better
- Not changing
- Getting worse

**How would you currently rate your symptoms?**

**Indicate where you have pain or other symptoms:**



none      0      1      2      3      4      5      6      7      8      9      10      unbearable

**How do your symptoms affect your ability to perform daily activities?**

0 1 2 3 4 5 6 7 8 9 10  
*no complaints* *mild, forgotten with activity* *moderate, interferes with activity* *limiting, prevents full activity* *intense, preoccupied with seeking relief* *severe, no activity possible*

**Who have you seen for your current symptoms?**

- No one       Medical Doctor       Other  
 Chiropractor       Acupuncturist       Massage Therapist

**What activities make your symptoms worse?** \_\_\_\_\_

**What activities make your symptoms better?** \_\_\_\_\_

**What tests have you had for your symptoms and when were they performed?**

- X-Ray: \_\_\_\_\_ (date)       MRI : \_\_\_\_\_ (date)       CT Scan: \_\_\_\_\_ (date)       Other: \_\_\_\_\_ (date)

**What type of regular exercise do you perform?** \_\_\_\_\_

**How has your sleep been? Before condition (Excellent/Good/Poor) Since condition started? (Excellent/Good/Poor)**

**For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.**

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/use of tobacco products
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss			
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis			
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder			
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer			
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Tumor			
			<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			

**Females Only:**

- Birth Control  
 Hormonal Replacement  
 Pregnancy

**Indicate if an immediate family member has had any of the following:**

- Rheumatoid Arthritis       Heart Problems       Diabetes       Cancer       Lupus       Other:

**List all prescriptions and over-the-counter medications and nutritional/herbal supplements you are taking:**

\_\_\_\_\_

**List all the surgical procedures and hospitalizations:**



## CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

### CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

#### Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

#### Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a

damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

**Alternatives**

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

**Questions or Concerns**

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

**Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

**DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR**

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

\_\_\_\_\_  
Name (Please Print)

Date: \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Signature of patient (or legal guardian)

Date: \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Signature of Chiropractor

Date: \_\_\_\_\_ 20\_\_\_\_.