MAHER CHIROPRACTIC

DISCOVERY - HEALTH DANGERS

PERSONAL INFORMATION

Name: _____

Address: _____

City _____ Postal/Zip Code: _____

Home/Cell Phone #: _____ Age: _____ Birth Date: (M) _____ (D) _____ (Y) _____ Gender: _____

Workplace: _____ Occupation: _____ Email: _____

Referred By: _____ ❍ Single ❍ Widowed ❍ Married (SPOUSE'S NAME): _____

# of Children: _____ Ages of Children: _____

Previous Chiropractic Experience: _____ Date of Last Adjustment: (M) _____ (D) _____ (Y) _____

PREVIOUS TRAUMAS

MOTORIZED VEHICLE ACCIDENTS:

Year:_____ Injuries:_____
Year:_____ Injuries:_____
Year:_____ Injuries:_____

- ○ High Speed Collisions >40km/h?
- ○ Vehicles Unrepairable?
- ○ Whiplash Injury?
- ○ Un-Belted Accident?

FALLS:

Falls from heights:_____
Falls down stairs:_____
Other falls:_____
Broken bones:_____
Childhood falls:_____
_____

Falls from:

- ○ Trees
- ○ Roof
- ○ Play structure
- ○ Bicycle

POSTURES & HABITS

- ○ Sitting >6 hours/day
- ○ Stomach Sleeper
- ○ Head Forward Posture

SPORTS & RECREATION:

Sports Injuries: _____
_____

Participation in High Impact Activities:

- ○ Hockey
- ○ Wrestling
- ○ Basketball
- ○ Running
- ○ Mountain Biking
- ○ Climbing
- ○ Football
- ○ Gymnastics
- ○ _____

OCCUPATIONAL STRESSES:

Occupation:_____
Tasks:_____
Work Injuries:_____
_____
Home Injuries:_____
My job requires:

- ○ Heavy Lifting
- ○ Awkward Positions
- ○ Repetitive Stresses
- ○ Sitting for Long Periods

YOUR BIRTH TRAUMA

- ○ Difficult
- ○ Forceps
- ○ C-Section
- ○ Epidural
- ○ Suction
- ○ Resuscitation

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DISEASE CAUSATION ANALYSIS

EXERCISE

Do you participate in aerobic exercise at least 30 minutes per day?

- ○ 0 Days / Week
- ○ 1-2 Days / Week
- ○ 3-4 Days / Week
- ○ 5-7 Days / Week

Do you lift weights or do resistance training?

- ○ P90x
- ○ CrossFit
- ○ Gym
- ○ Other:_____

What activities are you involved in that require balance?

- ○ _____
- ○ None

How often do you stretch per week?

- ○ 0 Days / Week
- ○ 1-2 Days / Week
- ○ 3-4 Days / Week
- ○ 5-7 Days / Week

EMOTIONAL STRESS

Are you currently experiencing, or have you ever experiences significant stress in the following areas?

- ○ Marriage/Relationship:_____
- ○ Kids:_____
- ○ Finances:_____
- ○ Work:_____
- ○ Elderly Parents – Caregiver: _____ _____
- ○ Recent Major Life Events (births, deaths): ___ _____

FAMILY HEALTH HISTORY

What significant health concerns have your family members experienced?

Parents / Siblings: _____ _____

Spouse / Partner: _____ _____

Children:_____ _____

CHEMICAL STRESSES: NUTRITION

Circle One:

Do you feel that you make healthy food choices?

Yes No Don't Know

Do you have a high intake of fruits and vegetables?

Yes No Don't Know

Do you have a high intake of lean meat for protein?

Yes No Don't Know

Are you at your ideal body weight?

Yes No Don't Know

CHEMICAL STRESSES: TOXICLOAD

Do you presently, or have you in the past:

- ○ Smoke?
- ○ Carry excessive weight?
- ○ Consume Alcohol?
- ○ Take recreational drugs?

MEDICATIONS

Condition:_____
Medication:_____

Condition:_____
Medication:_____

Condition:_____
Medication:_____

SURGERIES

Year:_____ Condition:_____

Year:_____ Condition:_____

Year:_____ Condition:_____

Any other details that may assist Dr. Maher in understanding your lifestyle and health status: _____

_____

_____

_____

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DISCOVERY - HEALTH DANGERS

WHAT IS YOUR PRESENT HEALTH CONCERN?

_____

_____

How long have you had this condition?

_____

Have you had a similar condition in the past?

_____

What activities aggravate your condition?

_____

What relieves your condition?

_____

Any pain or numbness in your arms or legs?

_____

Is your condition getting progressively worse?

- ○ Yes
- ○ Dull
- ○ No
- ○ Sharp
- ○ Burning
- ○ It's constant
- ○ Comes and goes

Pains are:

- ○ Tightness
- ○ Throbbing

Pain severity (Circle range, 0–no pain, 10–severe)

1 2 3 4 5 6 7 8 9 10

How is this condition interfering with your life?

- ○ Work
- ○ Daily Routine
- ○ _____

Other doctors (who have treated this condition):

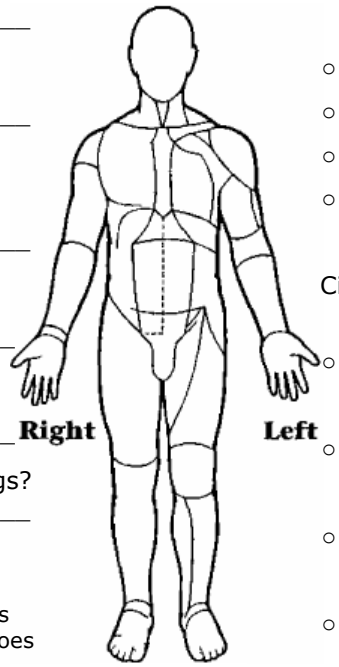
_____

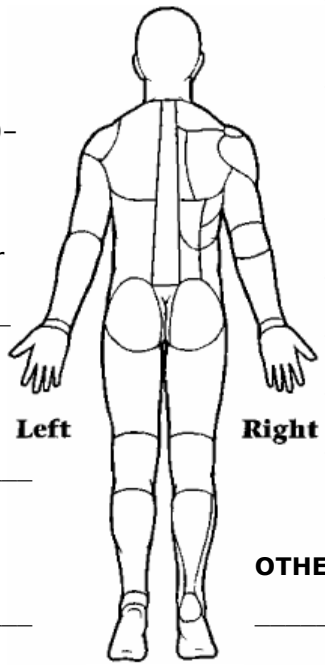
FAMILY HEALTH PROBLEMS?

_____

_____

_____





MARK WITH AN X ON THE DIAGRAM ANY PAST OR PRESENT PAIN OR PROBLEMS AND CHECK THE APPROPRIATE CIRCLE BELOW:

- ○ Headaches
- ○ Facial Pain
- ○ Vision Problems
- ○ Hearing Problems

Circle all that apply:

- ○ Shoulder: Pain/Numbness/Tingling
- ○ Arm: Pain/Numbness/Tingling
- ○ Hand: Pain/Numbness/Tingling
- ○ Hip: Pain/Numbness/Tingling
- ○ Knee: Pain/Numbness/Tingling
- ○ Foot: Pain/Numbness/Tingling

- ○ Neck Pain
- ○ Upper Back Pain
- ○ Middle Back Pain
- ○ Low Back Pain
- ○ Sacroiliac Pain

OTHER HEALTH PROBLEMS?

_____

_____

_____

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PLEASE CHECK ANY OF THE FOLLOWING SIGNS OF ORGAN MALFUNCTION OR DISEASE YOU HAVE EXPERIENCED:

- ○ Blurred/Failing Vision
- ○ Deafness/Ringing Ears
- ○ Earaches
- ○ Sore Throat/Tonsilitis
- ○ Thyroid Problems
- ○ Sinus Problems

Cardiovascular System

- ○ Chest Pain
- ○ Shortness of Breath
- ○ Heart Medication
- ○ High Blood Pressure Medication
- ○ High Cholesterol Medication
- ○ Swelling of Legs

Respiratory System

- ○ Frequent Bronchitis
- ○ History of Pneumonia
- ○ Chronic Cough
- ○ Spitting up Phlegm
- ○ Spitting up Blood
- ○ Difficulty Breathing
- ○ Tuberculosis

Digestive System

- ○ Heartburn / Indigestion
- ○ Stomach Cramps
- ○ Constipation / Diarrhea
- ○ Food Allergy
- ○ Irritable Bowel Syndrome
- ○ Crohn's Disease
- ○ Ulcers
- ○ Belching / Gas
- ○ Nausea or Vomiting
- ○ Liver / Gall Bladder Trouble
- ○ Colon Trouble
- ○ Black / Bloody Stool

Musculoskeletal System

- ○ Painful Joints
- ○ Painful Muscles
- ○ Tendonitis
- ○ Bursitis
- ○ Arthritis

- ○ Headaches / Migraine
- ○ Neck Pain / Stiffness
- ○ Tension in Shoulders: L or R
- ○ Mid-Back Pain / Stiffness
- ○ Numbness / Tingling: Hands or Arms

General Symptoms

- ○ Fever / Chills / Sweats
- ○ Frequent Colds
- ○ Fainting / Dizziness
- ○ Seizures / Convulsions
- ○ Skim Problems
- ○ Tremors
- ○ Loss of Balance
- ○ Unexplained Weight Loss or Gain
- ○ Anemia
- ○ Alcoholism
- ○ HIV / AIDS
- ○ Loss of Sleep
- ○ Poor Memory / Concentration
- ○ Learning Disability
- ○ Irritable / Nervous / Tension
- ○ Depression / Emotional
- ○ Decreased Energy / Fatigue
- ○ Tired / Lethargic
- ○ Autoimmune Disease
- ○ Antibiotic Use
- ○ Cancer: _____
- ○ Allergies / Asthma
- ○ Scoliosis / Spinal Curvature
- ○ Low Back Pain / Stiffness
- ○ Faulty Posture
- ○ Painful Tailbone
- ○ Foot Trouble: L or R

Females Only

- ○ Painful Menstruation
- ○ Cramps / Backaches
- ○ Passed Menopause
- ○ Currently Pregnant? Yes or No
- ○ Excessive / Irregular Flow
- ○ Abnormal Discharge
- ○ Miscarriages? #_____
- ○ Date of Last Menstrual Period: _____

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DISCOVERY - HEALTH DANGERS

PERSONAL INFORMATION

How has your condition affected your quality of life? _____

_____

How has your condition affected you emotionally? _____

_____

How has your condition affected your family life and/or relationships? _____

_____

If left uncorrected, how do you see your condition affecting your life over the next 1-5 years? _____

_____

If you are a candidate for spinal reconstruction and if we are having this conversation 12 months from today, what has to happen over that time to make you feel happy with your progress? _____

_____

What is your greatest motivation (other than pain) for seeking out a solution for your condition? (Mobility, quality of life, family, participation in sports, etc.) _____

_____

Do you believe that this condition can improve? _____

_____

INFORMED CONSENT TO INITIAL CHIROPRACTIC CONSULTATION AND EXAM

I understand that any insurance coverage is an arrangement between the insurance company and myself. I understand that your Chiropractic Clinic will prepare any necessary reports and forms to assist me in submitting a claim to the insurance company. Furthermore, I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

Our goal is to locate and correct vertebral subluxation, thereby restoring normal function to the spine and removing any interference to nerve function, maximizing the transmission of nerve impulses from the brain to the body. While we often see dramatic improvements in many diseases and conditions by restoring function to the spine and removing nerve interference, Chiropractic is not a treatment of any disease condition.

I understand and I am informed that, as in all health care, in the practice of Chiropractic there are some possible risks to care including, but not limited to: minor strains, sprains, and disc injuries. Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problem of the following – there have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are less than 1 in 5.8 million. Tests with or without X-Rays have been performed on you to minimize the risk to yourself. Chiropractic is considered to be one of the safest, most effective forms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor.

I have read the above statements and consent to the initial consultation and examination.

Signature: _____ Date: _____