

PATIENT HEALTH QUESTIONNAIRE

Date: _____
 Alta Health Care#: _____
 Name: _____
 Address: _____
 City: _____ Prov: _____
 Postal Code: _____
 Home Ph.: _____ Bus. Ph.: _____
 Birthdate: (d/m/y) _____ / _____ / _____ Age: _____
 Sex: M F

Business/Employer: _____
 Occupation: _____
 Emergency Contact: _____ Ph: _____
 Referred to this Office by: _____

E-Mail Address: _____
(For appointment reminders only)

CURRENT HEALTH CONDITION

- Purpose of this appointment: _____
- When did this condition begin: _____
- Cause of Injury: _____
- Current Medication: Nerve Pills Pain Killers/Muscle Relaxants Blood Pressure Medication Insulin
- Are you diabetic? Yes No If yes, are you on medication? Yes No
- Are you on thyroid medication? Yes No
- Are you a smoker? Yes No
- Have you ever had a surgery to the area in question? Yes No

1. a. Description of pain:
 Sharp Dull Ache Weak Throbbing
 Numb Tingling Shooting Spasm Burning

b. Frequency of pain:
 Intermittent (25% or less) Occasional (26-50%)
 Frequent (51-75%) Constant (76-100%)

c. Circle intensity of pain at lowest and highest level:
 Low 0 1 2 3 4 5 6 7 8 9 10 Unbearable

d. Your symptoms are:
 Decreasing Not changing Increasing

e. Symptoms are worse in the:
 Morning Afternoon Night
 Increases during day Decreases during day
 Same all day

2. What makes your problem better?
 Nothing Walking Standing Sitting
 Lying down Movement/Exercise Inactivity

3. What makes your problem worse? Nothing
 Lying down Walking Standing Sitting
 Movement/Exercise Inactivity

4. Have you had any special testing done for this condition (check all that apply):
 X-Ray MRI Ultrasound CT Scan
 EMG (Nerve Test) Other

5. Have you been treated for this episode? Yes No
 If yes, by whom?

MD _____
 Chiropractor _____
 Physiotherapist _____
 Massage Therapist _____
 Other _____

6. In the past have you been treated for the same or a similar problem? Yes No

If yes, who did you see for that episode? Chiropractor
 MD Massage Therapist Physical Therapist

Occupational Therapist Other _____
 When did you receive treatment? _____

7. General Physical Activity: None
 Light exercise program Moderate exercise program

8. Physical activity at work:
 Sitting more than 50% of work day
 Light manual labor Moderate Manual labor
 Heavy manual labor Repeated motion

9. What are your goals of treatment? (check all that apply):

pain/symptom relief
 regain full mobility
 improve flexibility
 improve strength
 home exercise program
 other _____

INFORMED CONSENT TO TREATMENT

Dr. Sean Bourassa, DC, BSc
Dr. Clay Ward, DC, BSc

The Ridge Spine & Sport Centre
Bay #3, 1026 – 7th Street S.W.
Medicine Hat, AB T1A 8V7

Doctors of chiropractic, medical doctors, physiotherapists and kinesiologists who use manual therapy techniques such as spinal adjustments, are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following 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.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor and/or physiotherapist the nature and purpose of treatment in general and my treatment in particular (including spinal adjustment in cases of chiropractic and/or physiotherapy), as well as the contents of this Consent.

I consent to the treatments offered or recommended to me by my chiropractor and/or physiotherapist including spinal adjustment. I intend this consent to apply to all my present and future care at this clinic.

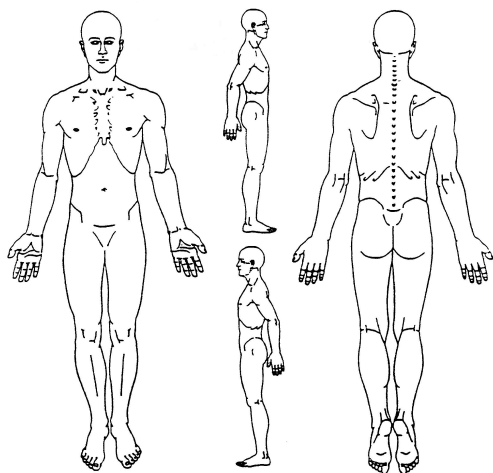
Dated _____, 20____

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____
(Please Print)

Name: _____
(Please Print)



PAIN DRAWING

Carefully shade or mark in the areas where you feel any pain