DYNAMIC
spine, sport & wellness

DATE:_____

PATIENT HEALTH QUESTIONNAIRE

Last Name:_____ First Name:_____
Address:_____
City:_____Province:_____ Postal Code:_____
Home Ph:_____ Bus. Ph:_____Cell Ph:_____
Birthdate: M:_____ D:_____ Y:_____ Age:_____ Family Doctor_____
Occupation:_____ Employer:_____
Spouse's Name:_____ Children's Name_____
What occupies your spare time? _____Who referred you to our office? _____
Medical Number:_____ ☐ MSP ☐ WCB ☐ ICBC ☐ Other:_____
Email:_____Would you like appointment reminders? ☐ Email ☐ Phone

CURRENT HEALTH INFORMATION

Have you had previous chiropractic care? ☐ yes ☐ no When?_____ Why?_____
What is your major complaint? _____
Cause of injury?_____How long have you had this condition? _____
Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily routine Other:_____
Current Medication: ☐ Pain Killers/Muscle Relaxants ☐ Nerve Pills ☐ Blood Pressure Medication
☐ Cholesterol Medication ☐ Thyroid Medication ☐ Vitamins Other:_____
Are you a smoker? ☐ Yes ☐ No
Are you wearing ☐ Heel lifts ☐ Orthotics ☐ Special supports or braces _____
Have you ever had surgery in the area of question? ☐ Yes ☐ No

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

b) Frequency of Pain:
☐ Intermittent ☐ Occasional ☐ Frequent ☐ Constant

c) Your symptoms are:
☐ Decreasing ☐ Not changing ☐ Increasing

d) Symptoms are worse in the:
☐ Morning ☐ Afternoon ☐ Night ☐ Increase during day
☐ Decrease during day ☐ Stay the same

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

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

4. Have you had any special tests done on this problem?
☐ X-ray ☐ MRI ☐ CT Scan ☐ EMG (nerve test)
☐ Ultrasound ☐ Other

5. Have you been treated for this episode?
☐ Yes ☐ No
If yes, by whom?
☐ MD ☐ Chiro ☐ Physio ☐ Massage ☐ Other

6. Have you been treated for this condition in the past? ☐ Yes ☐ No
If yes, by whom?
☐ MD ☐ Chiro ☐ Physio ☐ Massage ☐ Other

7. Physical Activity at work
☐ Sitting for 50+% of day ☐ Repeated motion
☐ Light manual labour ☐ Moderate manual labour
☐ Heavy manual labour ☐ Varied

8. General physical activity:
☐ None ☐ Light exercise program
☐ Moderate exercise program ☐ Training

What are your goals of treatment? (check all that apply)
☐ Pain/Symptom Relief ☐ Regain Full Mobility ☐ Improved Flexibility
☐ Spinal checkup and improved general health ☐ After my problem has been relieved, I am interested in strategies to ensure the problem doesn't return

HEALTH HISTORY

To provide us with a more complete clinical picture, please answer the following questions, even if you do not think they are related to your health problem. Pain is often referred from other areas or it may be related to a more serious underlying pathology**.**

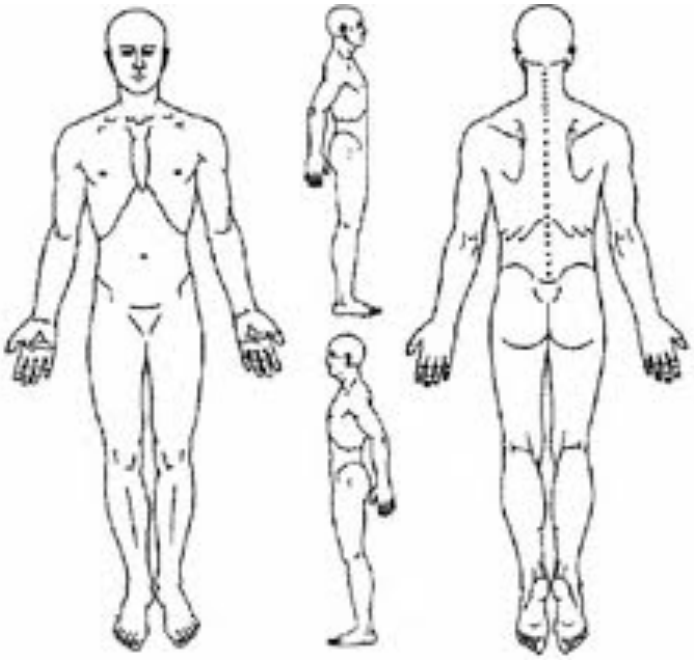
Have you ever suffered from:

1. Dizziness	☐ Yes	☐ No
2. Heart trouble	☐ Yes	☐ No
3. Diabetes	☐ Yes	☐ No
4. Arthritis	☐ Yes	☐ No
5. Asthma	☐ Yes	☐ No
6. Cancer	☐ Yes	☐ No
7. Digestive problems	☐ Yes	☐ No
8. Numbness	☐ Yes	☐ No
9. Tingling	☐ Yes	☐ No
10. Bladder trouble	☐ Yes	☐ No
11. Kidney trouble	☐ Yes	☐ No
12. Backaches	☐ Yes	☐ No
13. Neck pain	☐ Yes	☐ No
14. Headaches	☐ Yes	☐ No

Females:

1. Severe menstrual pain	☐ Yes	☐ No
2. Vaginal pain	☐ Yes	☐ No
3. Breast pain	☐ Yes	☐ No
4. Lumps on breast	☐ Yes	☐ No

Please mark the main areas of pain on the figures below



Make a mark (/) along the line which you think represents your current level of pain in your major area of injury, somewhere between "No Pain at all" and "Severe Pain"

No pain at all _____ Severe Pain

FAMILY HEALTH INFORMATION (Past or present health problems)

Mother: _____
Father: _____
Siblings: _____

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Dr. Clay Ward Inc.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Doctors of chiropractic who use manual therapy techniques 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 had 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 multidisciplinary 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 read the above and 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) as well as the contents of this consent.

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

_____
Patient Signature (Legal Guardian)

_____
Name (please print)

_____
Date

_____
Witness