

NOVO HEALTHNET LIMITED
CHIROPRACTOR HEALTH HISTORY QUESTIONNAIRE

DATE OF ASSESSMENT: _____

NAME: _____ DOB: _____

HOW & WHEN DID THIS START? _____

HAS THIS HAPPENED BEFORE? _____

IS THE PAIN LOCAL TO THE AREA OR DOES IT TRAVEL? _____

PLEASE IDENTIFY THE SEVERITY OF THE PAIN? NO PAIN 0 1 2 3 4 5 6 7 8 9 10 EXCRUCIATING PAIN

DESCRIBE THE PAIN: (sharp, dull, aching, burning, other)

WHAT AGGRAVATES YOUR COMPLAINT? _____

WHAT RELIEVES YOUR COMPLAINT? _____

HAVE YOU RECEIVED ANY CHIROPRACTIC/PHYSIOTHERAPY/MASSAGE THERAPY TREATMENTS FOR THIS COMPLAINT? _____

HAVE YOU RECEIVED ANY MEDICAL TREATMENT FOR THIS COMPLAINT? _____

HAVE YOU HAD ANY PREVIOUS TRAUMA OR ACCIDENTS? _____

ANY UNEXPLAINED WEIGHT LOSS? **YES / NO**

DO YOU HAVE A FAMILY HISTORY OF:

BLADDER / BOWEL PROBLEMS? **YES / NO**

HEART DISEASE _____ CANCER _____

FEVER OR NIGHT SWEATS? **YES / NO**

ARTHRITIS _____ DIABETES _____

CAN YOU SLEEP THROUGH THE NIGHT? **YES/NO**

OSTEOPOROSIS _____ OTHER _____

ARE YOU ON ANY MEDICATION? _____

DO YOU HAVE ANY ALLERGIES? _____

ANY PREVIOUS SURGERIES? _____

HOW MANY HOURS OF PHYSICAL ACTIVITY DO YOU PERFORM PER WEEK? _____

IS THIS CONDITION PREVENTING YOU FROM DOING ANYTHING? _____

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CHIROPRACTOR HEALTH HISTORY QUESTIONNAIRE

THE INFORMATION RECEIVED IS CONFIDENTIAL AND USED FOR THE PURPOSE OF ENHANCING YOUR CARE.

NAME: _____ TODAY'S DATE: _____

DOB: _____ HOME PHONE: _____

ADDRESS: _____ CELL PHONE: _____

EMAIL: _____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED COMMON LAW DIVORCED WIDOWED

EMERGENCY CONTACT: _____ PHONE: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US? _____

IS THIS A RESULT OF A MOTOR VEHICLE ACCIDENT? YES / NO

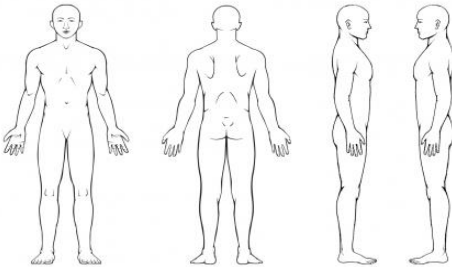
IS THIS A RESULT OF A WORK PLACE INJURY? YES / NO

CLAIM # _____

CLAIM# _____

DATE OF INJURY: _____ INSURANCE CONTACT: _____

PRIMARY COMPLAINT: _____



DO YOU SMOKE? YES / NO

PER WEEK: 1-10 / 10-50 / 50 +

DO YOU DRINK ALCOHOL? YES / NO

PER WEEK: 0-7 / 7-14 / 14+

OCCUPATION: _____

PLEASE CIRCLE ALL AREAS OF COMPLAINT ABOVE

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU.

- | | | | | |
|---------------------------|------------------------|----------------------|-----------------------------|---------------------|
| ____ HEADACHES | ____ FLUSHED FACE | ____ BACK PAIN | ____ NECK PAIN | ____ STIFF NECK |
| ____ DIZZINESS | ____ NUMBNESS | ____ IRRITABILITY | ____ FATIGUE | ____ PINS & NEEDLES |
| ____ COLD HANDS/FEET | ____ DEPRESSION | ____ RINGING IN EARS | ____ LOSS OF BALANCE | ____ ANXIETY |
| ____ SENSITIVITY TO LIGHT | ____ SLEEPING PROBLEMS | ____ MEMORY LOSS | ____ LOSS OF SMELL OR TASTE | ____ ACID REFLUX |
| ____ NAUSEA / VOMITING | ____ DIARRHEA | ____ CONSTIPATION | ____ SHORTNESS OF BREATH | ____ CHEST PAIN |

NOVO HEALTHNET LIMITED
CONSENT TO CHIROPRACTIC TREATMENT

Fees

Assessment- \$
Minor Assessment- \$
Treatment- \$
Modalities- \$

Cancellation Policy

We respectfully ask that you notify us at least 24 hours prior to your appointment time should you need to cancel or reschedule. If we are not provided with the appropriate notice, you will be responsible for a Missed Treatment charge of \$40.

Consent

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)

Signature of patient (or legal guardian)

Date: _____ 20____

Signature of Chiropractor

Date: _____ 20____

NOVO HEALTHNET LIMITED
CONFIDENTIAL CONSENT, AUTHORIZATION & DIRECTION TO DISCLOSE PERSONAL
INFORMATION

I, _____
(Print Full Name)

Of _____
(Print Full Address)

Hereby consent to the sharing and / or exchange of written and/or verbal information between Novo Healthnet Limited and:

(Print full names and institutions of affiliation)

In respect of

(Print name of the client)

(Date of birth)

Information to be released related to the above-named injury or illness and pertains to the development of treatment and nutritional plans.

I understand that this consent is subject to revocation at any time, except for such action that has already been taken.

A photocopy of this authorization shall have the same validity as the original.

Dated the _____ day of _____, 20____

(Witness)

(Signature)