

Nantais Family Chiropractic  
**Confidential Adult Patient Information Record**

Patient Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Email \_\_\_\_\_  
Birth Date (D/M/Y) \_\_\_\_\_ Age \_\_\_\_\_ Gender M \_\_\_ F \_\_\_ Status M\_ S\_ W\_ D\_  
Business/Employer \_\_\_\_\_ Type of work \_\_\_\_\_  
Business phone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Children's ages \_\_\_\_\_

Whom shall we thank for referring you to our office? \_\_\_\_\_

*Why is this form important?* As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. This patient information form will uncover any layers of damage, especially to your nervous system, allowing us to better assess any challenges to your health potential and then along with an examination, to outline a course of care so you may reach your health destiny.

If you have no specific symptoms or complaints and are here mainly for wellness services, please check here \_\_\_\_\_.

If you have symptoms, please briefly describe: primary \_\_\_\_\_;  
secondary \_\_\_\_\_.

Since the primary problem started, is it: About the same \_\_\_ Getting better \_\_\_ Getting worse \_\_\_  
What makes it worse?  
\_\_\_\_\_.

What relieves this condition?  
\_\_\_\_\_.

It interferes with: Work \_\_\_ Sleep \_\_\_ Walking \_\_\_ Sitting \_\_\_ Hobbies \_\_\_ Leisure \_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had a similar condition in the past? Y\_\_\_ N\_\_\_

If you are experiencing pain, is it: Sharp \_\_\_ Dull \_\_\_ Travels \_\_\_ Constant \_\_\_ Intermittent \_\_\_ Burning \_\_\_  
Throbbing \_\_\_ Tight \_\_\_

Are you getting pain (P) and/or numbness (N) in: Arms L\_\_\_ R\_\_\_; Hands L\_\_\_ R\_\_\_; Legs L\_\_\_ R\_\_\_;  
Feet L\_\_\_ R\_\_\_; Buttocks L\_\_\_ R\_\_\_; Head \_\_\_

Is this pain/numbness getting progressively worse? Y \_\_\_ N \_\_\_. Is it constant? Y \_\_\_ N \_\_\_. Does it  
come/go? Y \_\_\_ N \_\_\_

Have you had previous chiropractic care? Y\_\_\_ N\_\_\_ Why? \_\_\_\_\_

When? \_\_\_\_\_ Were X-rays taken? Y \_\_\_ N\_\_\_

Chiropractor's name \_\_\_\_\_

Please rate your level of commitment to resolving this/these problem(s) (10 being the highest):

1\_\_ 2\_\_ 3\_\_ 4\_\_ 5\_\_ 6\_\_ 7\_\_ 8\_\_ 9\_\_ 10\_\_

Family Physician's name \_\_\_\_\_

History:

1. Were you involved in any car accidents: as a child N \_\_ Y \_\_ Age? \_\_\_\_ Describe any injuries? \_\_\_\_

Were you involved in any car accidents as an adult N \_\_ Y \_\_ Age? \_\_\_\_ Were you the driver? \_\_  
passenger? \_\_ Injuries: Describe \_\_\_\_\_

Other \_\_ Age? \_\_\_\_ Were you the driver? \_\_  
passenger? \_\_ Injuries: Describe \_\_\_\_\_

2. Have you fallen/jumped from a height over 3 feet: as a child? N \_\_ Y \_\_ Age? \_\_\_\_ Any injuries?  
Describe \_\_\_\_\_

Have you fallen as an adult? N \_\_ Y \_\_ Age? \_\_ Any injuries? \_\_ Describe \_\_\_\_\_

3. Have you had any surgeries as a child? N \_\_ Y \_\_ Age? \_\_\_\_ Describe \_\_\_\_\_

Have you had any surgeries as an adult? N \_\_ Y \_\_ Age? \_\_\_\_ Describe \_\_\_\_\_

Other \_\_ Age? \_\_\_\_ Describe \_\_\_\_\_

4. Did you take any drugs as a child? N \_\_ Y \_\_ Describe \_\_\_\_\_

Drugs you presently take: Anti-inflammatory\_\_ Pain Killers\_\_ Muscle Relaxers\_\_ Blood Pressure\_\_

Tranquilizers\_\_ Insulin\_\_ Birth Control\_\_ Other: \_\_\_\_\_

5. On a scale of 1-10 rate your stress level (1=none, 10=severe) Occupational \_\_\_\_ Personal \_\_\_\_

6. Were you delivered: Naturally\_\_ C-section\_\_ Forceps\_\_ Vacuum\_\_ Mom induced\_\_ Breech\_\_ Unsure \_\_

7. Did you suffer any sports traumas? N \_\_ Y \_\_ When? \_\_\_\_\_ What? \_\_\_\_\_

8. Did you suffer any work traumas? N \_\_ Y \_\_ When? \_\_\_\_\_ What? \_\_\_\_\_

9. Were you vaccinated as a child? N \_\_ Y \_\_

10. Did you have any childhood illnesses? N \_\_ Y \_\_ What/When? \_\_\_\_\_

11. Female patients-is there a possibility that you are pregnant? Y\_\_N\_\_ Trying\_\_ Unsure\_\_ Date of last  
menstrual period \_\_\_\_\_.

Please check off ALL of the following if you have this NOW or in the PAST:

N\_\_P\_\_ Loss of sleep

N\_\_P\_\_ Dizziness

N\_\_P\_\_ Fatigue

N\_\_P\_\_ Confusion

N\_\_P\_\_ Forgetfulness

N\_\_P\_\_ Imbalance

N\_\_P\_\_ Migraines

N\_\_P\_\_ Neck pain

N\_\_P\_\_ Arm pain

N\_\_P\_\_ Shoulder pain

N\_\_P\_\_ Pain between shoulder  
blades

N\_\_P\_\_ Leg pain

N\_\_P\_\_ Knee pain

N\_\_P\_\_ Foot pain

N\_\_P\_\_ Arthritis

N\_\_P\_\_ Herniated disc

N\_\_P\_\_ Numbness/tingling

N\_\_P\_\_ Allergies \_\_\_\_\_

N\_\_P\_\_ Pinched nerves

N\_\_P\_\_ Low back pain

N\_\_P\_\_ Hip pain

N\_\_P\_\_ Walking problems

N\_\_P\_\_ Morning stiffness

N\_\_P\_\_ Buzzing/ringing in ears

N\_\_P\_\_ Chronic infections

N\_\_P\_\_ Decreased immunity

N\_\_P\_\_ Frequent colds

N\_\_P\_\_ Shortness of breath

N\_\_P\_\_ Heart/vascular problems

N\_\_P\_\_ Heart disease/chest pains

N\_\_P\_\_ Blood pressure problems

N\_\_P\_\_ Ankle swelling

N\_\_P\_\_ Frequent nausea

N\_\_P\_\_ Ulcers/heartburn

N\_\_P\_\_ Upset stomach

N\_\_P\_\_ Liver Problems

N\_\_P\_\_ Gall bladder problems

N\_\_P\_\_ Diarrhea

N\_\_P\_\_ Constipation

N\_\_P\_\_ Bladder problems

N\_\_P\_\_ Painful urination

N\_\_P\_\_ Thyroid problems

N\_\_P\_\_ Diabetes

N\_\_P\_\_ Teeth problems

N\_\_P\_\_ Eye problems

N\_\_P\_\_ Hearing problems

N\_\_P\_\_ Mood swings

N\_\_P\_\_ Depression

N\_\_P\_\_ Sexual dysfunction

N\_\_P\_\_ Breast pains

N\_\_P\_\_ Menstrual irregularity

N\_\_P\_\_ Miscarriage(s)

N\_\_P\_\_ Osteoporosis

N\_\_P\_\_ Cancer of \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Nantais Family Chiropractic

Dr. Brian J. Nantais, B.H.K., D.C.

## INFORMED CONSENT

Chiropractic does NOT treat disease and our college will not allow us to guarantee results or cure of the condition that you came to us with. When a patient seeks Chiropractic care and when a Chiropractor accepts a patient for such care, it is essential that both understand and are working towards the same goal.

The goal is to locate, analyze and correct interference to the nervous system.

The purpose of the nervous system is to control and coordinate all bodily function. Interference in this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxations through a specific Chiropractic adjustment allows the body to function at its optimal level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain and promote health.

I hereby request and consent to the performance of Chiropractic adjustment and other Chiropractic procedures including diagnostic x-rays, if necessary, on me, and or my legal dependant, by the doctor and or anyone working in this clinic authorized by the doctor.

I understand and I am informed that, as in all health care, in the practice of Chiropractic there are some minimal risks to care including but not limited to: minor muscle strains and sprains, disc injuries, rib fractures, and stroke. I understand that the current research shows an association between vertebrobasilar artery stroke and chiropractic visits as equal to the association of vertebrobasilar artery (VBA) stroke and a medical doctor visit. In conclusion, there is no evidence of excess risk of VBA stroke associated with chiropractic care (1). I do not expect the doctor to be able to anticipate or explain all risks and complications. I expect the doctor to exercise and employ clinical judgement, physical exam and screening procedures during the course of my care.

If the treating Chiropractor is away and another Chiropractor is recommended to treat that patient, I, the patient will consent to this treatment by the referred to chiropractor, who is located at this or another office.

I have read this above consent. I will have an opportunity to ask questions about its consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of care for my present condition and for any further condition(s) for which I seek care in this office.

## TO BE COMPLETED BY THE PATIENT

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature

(Custodial Parent or Guardian, if under 18 years old)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date