ATLAS CHIROPRACTIC & FAMILY WELLNESS

# Adult Intake

2950 Dundas St. West
Toronto, ON M6P 1Y8
416-766-6572
info@atlashealth.ca
www.atlashealth.ca

**TODAY'S DATE:** (DD/MM/YY)

**First Name**:_____ **Last Name**:_____

Address:_____ City/Province:_____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email: _____ Birth Date (DD/MM/YY):_____ Age:_____

Gender: ☐Male , ☐Female , ☐Other Height: _____ Weight:____ Occupation: _____

Emergency Contact:_____ Relation: _____ Emergency Phone #:_____

**We are a family practice; please tell us about your family:**

Marital Status: ☐S, ☐M, ☐D, ☐W, ☐CL, ☐other: _____ Spouse's Name: _____

# of Children:_____ Names & Ages:_____

**How did you hear about us?** ☐Walked by, ☐Internet, ☐Talk/Presentation, ☐ Referral :_____

**CURRENT HEALTH CONDITIONS:**

What is your reason for seeking care at Atlas Chiropractic? _____

Have you received care for this before? ☐ No ☐Yes

**If Yes, please explain**: _____

_____

When did this condition start? ☐Suddenly, ☐Gradually, ☐ Post-Injury

**Is the condition:** ☐ Worse ☐Improving ☐Intermittent ☐Constant

What makes the condition better?_____

What makes the condition worse?_____

What is this affecting most in your life (List all that apply)?

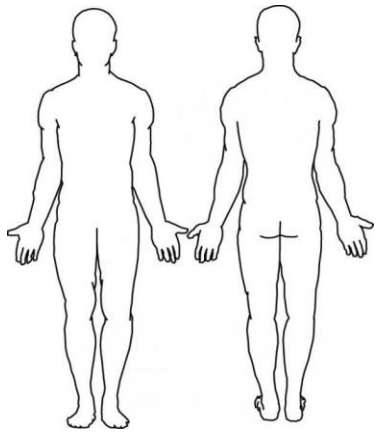
_____

Have you seen any other providers for this condition? (Please specify)

_____

_____

***Please mark (x) where you feel pain or discomfort***



Have you seen a chiropractor before? ☐ No ☐Yes - **If Yes -** How long ago?_____

Reason for the Change:_____

What would you like to gain from chiropractic care? ☐Resolve Existing Conditions, ☐ Overall Wellness, ☐ Both

Do you have any health concerns for other family members today? _____

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**HEALTH GOALS**: List the top 3 things you want to achieve from seeking care at our office:

1. _____

2. _____

3. _____

What health goal, if you were to accomplish it, would have the greatest impact on your life? ☐ 1, ☐ 2, ☐ 3

What is your level of commitment to your health? (1 – Not Committed, 10 – Very Committed): _____

Explain: _____

**TRAUMAS: Physical Injury History**

Have you ever had any significant falls, surgeries, hospitalizations, broken bones or other injuries? ☐ No ☐Yes

**If Yes**, please explain: _____

_____

Notable childhood injuries? ☐No ☐Yes, **explain**: _____

Youth or University Sports? ☐No ☐Yes, **explain**: _____

Any car accidents? ☐No ☐Yes, **explain**: _____

Exercise Frequency: ☐None ☐ 1-2x/week ☐ 3-5x/week ☐ daily

Types of exercise? _____

How do you normally sleep? ☐ Back, ☐ Side, ☐ Stomach; Do you wake up: ☐ Refreshed & Rested ☐Stiff & tired

Do you commute to work? ☐No ☐ Yes, **If yes,** how many minutes/day: _____

How many hours per day do you typically spend sitting at a desk, on a computer, tablet or phone? _____

**PAST MEDICAL HISTORY**

Do you have any history of: ☐Cancer ☐Stroke ☐Diabetes ☐High Blood Pressure ☐High Cholesterol ☐N/A

**If yes to any above, please explain:** _____

_____

Is there any significant personal or family medical history we should know about? _____

**Do you have any allergies?** ☐ No ☐ Yes: _____

**Have you had any of the following childhood conditions?**

| | | | | |
|---|---|---|---|---|
| ☐ Chicken Pox | ☐ Whooping Cough | ☐ Scarlet Fever | ☐ Mumps | ☐ Measles |
| ☐ Ear Infections | ☐ Tubes in Ears | ☐ Chronic Illness | ☐ Typhoid | ☐ Hepatitis |
| ☐ Diphtheria | ☐ Rheumatic Fever | | | |

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**THOUGHTS: Emotional Stresses & Challenges**

Please rate your STRESS for each:

| | None | | Moderate | | High | | None | | Moderate | | High |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Home** | O | O | O | O | O | **Money** | O | O | O | O | O |
| **Work** | O | O | O | O | O | **Health** | O | O | O | O | O |
| **Life** | O | O | O | O | O | **Family** | O | O | O | O | O |

**TOXINS: Chemical and Environmental Exposures**

Please rate your consumption of each:

| | None | | Moderate | | High | | None | | Moderate | | High |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Alcohol** | O | O | O | O | O | **Processed Foods** | O | O | O | O | O |
| **Water** | O | O | O | O | O | **Artificial Sweeteners** | O | O | O | O | O |
| **Sugar** | O | O | O | O | O | **Sugary Drinks** | O | O | O | O | O |
| **Dairy** | O | O | O | O | O | **Cigarettes** | O | O | O | O | O |
| **Gluten** | O | O | O | O | O | **Recreational Drugs** | O | O | O | O | O |

Are you currently taking any medications: ☐No ☐Yes: _____

Are you currently taking any supplements/vitamins: ☐No ☐Yes: _____

Is there anything else that we should know about? ☐No ☐Yes:_____

_____

**By signing below, I consent to a patient history and physical examination:**

Signature: _____

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## Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

*Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.*

| REGIONS | FUNCTIONS | SYMPTOMS (PAST / PRESENT) | | SYMPTOMS (PAST / PRESENT) | |
|---|---|---|---|---|---|
| Cervical | • Autonomic Nervous System<br>• ENT System<br>• Vision, Balance & Coordination<br>• Speech<br>• Immune System<br>• Digestive System<br>• Nerve Supply to Shoulders, Arms & Hands<br>• Sympathetic Nucleus<br>• Metabolism | ☐☐ | Colic & Excessive Crying<br>Ear & Sinus Infections<br>Allergies & Congestion<br>Immune Deficiency<br>Headaches & Migraines<br>Vertigo & Dizziness<br>Sore Throat & Strep<br>Swollen Tonsils & Adenoids<br>Vision & Hearing Issues<br>Low Energy & Fatigue<br>Difficulty Sleeping<br>Pain, Numbness & Tingling in Arms to Hands | ☐☐ | Epilepsy & Seizures<br>Sensory & Spectrum<br>ADD / ADHD<br>Focus & Memory Issues<br>Anxiety & Stress<br>Balance & Coordination<br>Speech Issues<br>TMJ / Jaw Pain<br>Stiff Neck & Shoulders<br>Depression<br>High Blood Pressure<br>Poor Metabolism & Weight Control |
| Upper Thoracic | • Upper G.I.<br>• Respiratory System<br>• Cardiac Function | ☐☐ | Reflux / GERD<br>Chronic Colds & Cough<br>Asthma | ☐☐ | Bronchitis & Pneumonia<br>Functional Heart Conditions |
| Mid Thoracic | • Major Digestive Center<br>• Detox & Immunity | ☐☐ | Gallbladder Pain / Issues<br>Jaundice<br>Fever | ☐☐ | Indigestion & Heartburn<br>Stomach Pains & Ulcers<br>Blood Sugar Problems |
| Lower Thoracic | • Stress Response<br>• Filtration & Elimination<br>• Gut & Digestion<br>• Hormonal Control | ☐☐ | Behavior Issues<br>Hyperactivity<br>Chronic Fatigue<br>Chronic Stress | ☐☐ | Allergies & Eczema<br>Skin Conditions / Rash<br>Kidney Problems<br>Gas Pain & Bloating |
| Lumbar, Sacrum & Pelvis | • Lower G.I. (Absorption & Motility)<br>• Gut-Immune System<br>• Major Hormonal Control | ☐☐ | Constipation<br>Chrohn's, Colitis & IBS<br>Diarrhea<br>Bed-wetting<br>Bladder & Urination Issues<br>Cramps & Menstrual Issues<br>Cysts & Endometriosis<br>Infertility<br>Impotency<br>Hemorrhoids | ☐☐ | Sciatica & Radiating Pain<br>Lumbopelvic / SI Joint Pain<br>Hamstring Tightness<br>Disc Degeneration<br>Leg Weakness & Cramps<br>Poor Circulation & Cold Feet<br>Knee, Ankle & Foot Pain<br>Weak Ankles & Arches<br>Lower Back Pain<br>Gluten & Casein Intolerance |

Patient Name: _____ Date: DD /MM/ YY

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## CONSENT TO CHIRPRACTIC TREATMENT

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 is there is a pre-existing condition, chiropractic treatment, like many 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 bowl or bladder functions or impaired leg or arm function. Surgery may be needed.

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•**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.

**Alternatives**

Alternatives to chiropractic treatment many include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatments.

**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 the treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
**Name (Please Print)**

_____ **Date: _____ 20/___**
**Signature of Patient (or Legal Guardian)**

_____ **Date: _____ 20/___**
**Signature of Chiropractor**

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**Photo & Video Waiver Form**

I, _____, hereby grant permission to Atlas Chiropractic (AC) to take and use any pictures or videos taken at AC for the sole purpose of illustrating and promoting the activities of AC's Services and Products. Pictures and videos in any and all of its publications and in any and all other media, whether now known or hereafter existing, controlled by AC, can be used in perpetuity, and for advertising, marketing, or other uses by AC. I will make no monetary or other claim against AC for use of pictures and videos, and I hereby release AC from all liability from use of pictures and videos.

I am aware that pictures and videos taken AC are considered the property of AC and may not be sold or reused without express written consent of AC.

AC reserves your right to withdraw consent at any time – simply let us know.

By signing this form I confirm that I have read, understand and agree to be bound by it.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date