BALES FAMILY CHIROPRACTIC CENTRE

180 Parsons Rd., #11, Alliston, ON L9R 1E8 Dr. Scott P. Bales

Confidential Patient Information

Name_____ Sex M F Date _____

Date of Birth _____ Age _____ Occupation _____
(day/month/year)

Address_____ City _____ Postal Code _____

Phone: Home _____ Work _____ Cell _____

Email: _____ Marital Status _____

Health Insurance Y N Children's Names & Ages _____

How did you hear about our office? _____

Current Major Complaints _____

How long have you had this condition? _____ Is it getting: worse___ better___ constant___

Previous diagnosis and/or treatment for present condition: _____

Have you had previous chiropractic care? _____ When? _____ Who? _____

Medical doctor's name _____ City _____

Family Health Information: Many health problems are the result of hereditary spinal weakness. Information about your family members will give us a better picture of your total health. Please list your immediate family members who have had any type of illness or disease.

Name	Relationship	Past and Present Health Problems

Please List Any:

Medications you take (including aspirin, birth control, etc.) _____

Surgeries, car accidents, falls _____

Over-night hospital stays _____

Broken/fractured bones you have had _____

Canes, crutches, or supports you have used _____

Loss of consciousness or altered mental states _____

Circle the conditions you have had or been treated for

ADD/ADHD	Alcoholism	Allergies	Anemia	Appendicitis
Arteriosclerosis	Arthritis	Asthma	Cancer	Cold sores
Diabetes	Diphtheria	Eczema	Emphysema	Venereal Disease
Epilepsy	Thyroid	Ulcers	Stroke	High Blood Pressure
Heart disease	Hepatitis	HIV/Aids	Infertility	Measles
Migraines	Mumps	Pertusis	Pneumonia	Rheumatic Fever
Polio	Rubella	Tetanus	Tuberculosis	Multiples Sclerosis

Other (please specify) _____

Psychosocial: have any of the following occurred recently?

Alcohol increase	Anxiety	Change in job	Chronic fatigue
Death in family	Depression	Divorce	Family problems
Drug use	Economic stress	Work stress	Sleep disturbances

Other (please specify) _____

Nutrition and Lifestyle

Do you skip meals regularly? If so, how often? _____ Coffee/tea Consumption ____ per day

Alcoholic beverages ____ per week Tobacco Use ___ per day

List all vitamins or supplements you take _____

Personal satisfaction with diet: Highly satisfied__Satisfied__Unsatisfied__Highly unsatisfied __

What exercise do you do on a regular basis and how often? _____

Date of Last:

Spinal Examination _____ Physical Examination _____

Spinal X-ray _____ Other Tests (blood, urine etc.) _____

For Women Only: When did you last period start? _____Are you pregnant? Yes No Maybe

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I have read the above, and agree and understand that I am personally responsible for all charges relating to my treatment at the clinic. Furthermore, I give Dr. Bales my consent to complete a consultation and physical examination on me.

Date: _____ Signature: _____

Date: _____ Guardian: _____
(if patient is under 18 years of age)

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains and sprains, disc injuries, rib fractures and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read the above consent.
I have also had an opportunity to ask questions about its content,
And by signing below I agree to the above named procedures.
I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patients name (please print) _____ Signature of patient (or parent/guardian) _____

Date signed _____ Witness to signature above _____

FOR OFFICE USE ONLY

Dr. Scott Bales or Bales Family Chiropractic Centre

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