WINDSORCHIROPRACTIC + wellness

Dr. Meagan Tsagaris BHK, DC

Confidential Patient Information

All information taken by our team is confidential and will be used for the purposes of enhancing your care in the clinic.

PATIENT CONTACT INFORMATION

Today's Date (DD/MMM/YYYY)______________________

Name:____

Phone: H:_________________________W:_______________________________C:________________________

Email:____

Address____

City____________________________________Province____________________ Postal Code_________________

PATIENT INFORMATION

Birth Date (D/M/Y)_________________________Weight _____________Height_______________Gender F M

Marital Status (S / M / W / D / Common-law) # of Children________________________

Occupation_______________________________ Employer______________________________________

Referred to this office by________________________ Family M.D.____

I give permission for Windsor Chiropractic & Wellness to contact my physician. ☐ No ☐ Yes

Do you have Extended Health Coverage? ☐ No ☐ Yes (SunLife, Blue Cross, Great West Life, Green Shield, Manulife etc.)

☐ **I would like to receive Windsor Chiropractic & Wellness newsletters, updates and promotions regarding Windsor Chiropractic & Wellness products and services. You can withdraw your consent at anytime.**

CHIROPRACTIC AND YOUR HEALTH

Please check one of the following:

☐ I have a specific health issue, pain, or disability and am here for resolution of these symptoms only.

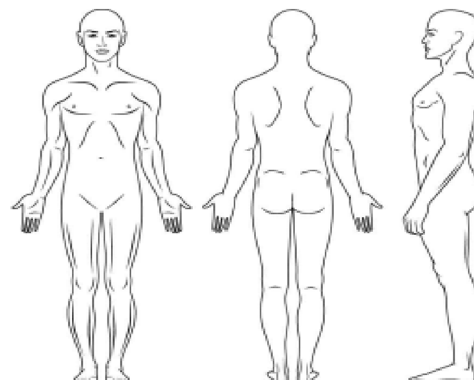
☐ In addition to symptom relief, I am interested in learning about strategies to prevent problems from recurring.

☐ I have no specific complaint, but I am interested in improving and maintaining health to maximize my potential.

CURRENT HEALTH CONDITION

In the diagrams provided, please mark the areas of your body that you feel best represent the discomfort(s) or sensation(s) you are experiencing.
Use the symbols provided below.

Numbness:	////
Burning:	x x x
Dull and aching:	+ + +
Pins and needles:	* * *
Sharp and stabbing	= = =
Stiff and tight	2 2 2



WINDSORCHIROPRACTIC + wellness WCW

Dr. Meagan Tsagaris BHK, DC

Patient Name: ____

Present complaint____

Have you had any previous treatment for this condition? ____

☐ Chiropractic ☐ Massage ☐ Physiotherapy ☐ Surgery ☐ Other__________________________

When did this condition begin? ____

What do you believe caused this condition? ____

Is this the first time this has occurred? ____

Identify the severity of your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (pain as bad as it could be)

Describe the nature of your pain: (sharp, dull, aching, etc.) ____

Is there anything that aggravates the pain? ____

Is there anything that relieves the pain? ____

Have you had any time loss from work for this condition? (If recent list dates) _______________________________

Are you presently taking medication? (please list) ____

Have you had any recent unexplained weight loss? ☐ Yes ☐ No Any unexplained fever or night sweats? ☐ Yes ☐ No

PRESENT HEALTH Please check any that are relevant (within the past three months)

MUSCLE AND JOINT

☐ Back pain
☐ Neck pain
☐ Stiff neck
☐ Shoulder pain
☐ Foot trouble
☐ Scoliosis
☐ Arthritis
☐ Poor posture
☐ Bursitis
☐ Sciatica
☐ TMJ / TMD
☐ Hip Pain
☐ Knee Pain
☐ Elbow/Wrist Pain

GENERAL SYMPTOMS

☐ Fevers/Chills/Sweats
☐ Fainting
☐ Loss of balance
☐ Fatigue/ Loss of energy

RESPIRATORY

☐ Chronic cough
☐ Coughing up blood/phlegm
☐ Asthma

CARDIOVASCULAR

☐ Chest pain / Pain over heart
☐ Shortness of breath
☐ High blood pressure

STRESS SYMPTOMS

☐ Headache/Migraine
☐ Sensitivity to light
☐ Numbness or pins and needles in hands/feet
☐ Ringing in ears
☐ Loss of sleep
☐ Loss of concentration
☐ Tension

FEMALES ONLY

☐ Painful menstruation
☐ Excessive flow
☐ Menopause
☐ Pregnant

GASTROINTESTINAL

☐ Constipation
☐ Diarrhea
☐ Heart Burn

OF SPECIAL NOTE

Presence of:
☐ Internal pins/wires
☐ Pacemaker
☐ Artificial joint
☐ Special equipment

PAST HEALTH Have you ever suffered from any of the following conditions?

☐ Alcoholism ☐ Diabetes ☐ Hepatitis ☐ Pneumonia ☐ Stroke ☐ Surgery
☐ Aneurysm ☐ Epileptic seizures ☐ HIV ☐ Polio ☐ Tuberculosis Type: ____________
☐Cancer☐ Heart disease ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ VD / STD Date: ____________

CONSENT TO CHIROPRACTIC 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 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.

_______________________________________ Date: _______________ 20____.
Name (Please Print)

_______________________________________ Date: _______________ 20____.
Signature of patient (or legal guardian)

_______________________________________ Date: ________________20____
Signature of Chiropractor