Personal and Family Health History

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M F

Address: _____ City: _____

Province: _____ Postal Code: _____ Alberta Health #: _____

Phone: Home: _____ Cell: _____

Occupation: _____ Employer: _____

Email: _____ Marital Status: S M D W

Referred by: _____ Spouse Name: _____

Emergency Contact: _____ Phone: _____

Consent for Email Communication:

Email communication will be used in reference to your personalized treatment plan in the form of exercise prescriptions, newsletters, updates regarding clinic events/closures, and other wellness information that the practitioner believes will be beneficial to your care. Your contact information will not be extended to other parties outside of the Divine Spine professionals and will not be used for the distribution of any materials not considered to be part of your treatment plan.

Initials: _____

Have you received previous spinal care? Y N

Do you have any children? Y N

Names: _____ _____ _____ _____

Ages: _____ _____ _____ _____

Have they received spinal care? Y N

Current Health Condition:

Present Complaint or Pain? If no current pain, what is the reason for your visit today?

Major _____

Pain or Problem started on _____

Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Other Practitioners seen for this condition: _____

Any home remedies? _____

Is this a work related injury? Y N Motor Vehicle injury? Y N Date of Occurrence:_____

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ring	❒ Diarrhea
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Depression
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Fatigue
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Dizziness
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Loss of Balance	❒ Loss of Taste	
❒ Buzzing in Ear	❒ Constipation	❒ Stomach Upset	

If female, are you pregnant? Y N

Have you been under drug/medical care? _____ How long?_____

What medications are you taking? _____

Have you had surgery? Y N What?_____ When? _____

What side effects have you experienced from the drugs/surgery? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

What age did your oldest grandparents on record live to? _____ Still Living? Y N

As a result of your care would you like to *(check all that apply)*

❒Get better quickly ❒Live a healthier lifestyle ❒Have a healthier spine and nervous system

You may not know this, but Divine Spine is pleased to offer you a 100% Satisfaction Guarantee. This is not a guarantee of results, however we DO guarantee we will do everything we reasonably can to help you and that you will be satisfied with the level of service you have received. If, for any reason you are not satisfied, you may request a full refund. This offer must be exercised within the first three office visits. Continuing care past the first three appointments will be taken as an indication of your satisfaction and the guarantee will expire.

Signature: _____ Date: _____

Activities of Daily Living Evaluation

Name: _____ **Date:** _____

ADL's / Recreation - ADL stands for Activities of Daily Living. Living in pain can be debilitating. This exercise is to help both you and your Doctor determine which areas of your life are affected by your pain and how we can better help serve you. Examine how your pain has impacted your day to day living and set goals with your Doctor for areas of improvement.

When answering the following questions, please check the appropriate box use the following scale:
No Effect – you are able to perform the activity at your full potential
Mild – you are able to perform the activity, however you experience mild pain when doing so
Mod – you are able to perform the activity to a limited degree and it is moderately painful to do so
Sev – you are unable to perform the activity or it causes severe pain

How has your condition affected your recreational activities? □ No Effect □ Mild □ Mod □ Sev
How has your condition affected your job performance? □ No Effect □ Mild □ Mod □ Sev

How does your current condition affect the following daily activities?

Bending:	□ No Effect	□ Mild	□ Mod	□ Sev
Carrying Groceries:	□ No Effect	□ Mild	□ Mod	□ Sev
Climbing Stairs:	□ No Effect	□ Mild	□ Mod	□ Sev
Driving:	□ No Effect	□ Mild	□ Mod	□ Sev
Extended Computer Use:	□ No Effect	□ Mild	□ Mod	□ Sev
Household Chores:	□ No Effect	□ Mild	□ Mod	□ Sev
Kneeling:	□ No Effect	□ Mild	□ Mod	□ Sev
Lifting:	□ No Effect	□ Mild	□ Mod	□ Sev
Reading (concentration):	□ No Effect	□ Mild	□ Mod	□ Sev
Hygiene Practices:	□ No Effect	□ Mild	□ Mod	□ Sev
Sexual Activities:	□ No Effect	□ Mild	□ Mod	□ Sev
Sleep:	□ No Effect	□ Mild	□ Mod	□ Sev
Static Sitting:	□ No Effect	□ Mild	□ Mod	□ Sev
Static Standing:	□ No Effect	□ Mild	□ Mod	□ Sev
Walking:	□ No Effect	□ Mild	□ Mod	□ Sev
Yard Work:	□ No Effect	□ Mild	□ Mod	□ Sev

Rate your level of overall impairment when resting: **0 1 2 3 4 5 6 7 8 9 10**

Rate your level of overall impairment with activity: **0 1 2 3 4 5 6 7 8 9 10**

Informed Consent to Treatment Form

Your treatments at Divine Spine may be performed by a Registered Massage Therapist, a Chiropractor, a Manual Osteopath, or any other professional who is certified in Joint Mobilization and has successfully completed training to become a Certified Divine Spine Therapist. While Divine Spine focuses on offering gentle, computerized treatments, there are risks and possible risks associated with manual therapy techniques used by Chiropractors. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my practitioner the nature and purpose of Divine Spine treatment in general, (including chiropractic spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the treatment recommended to me by my practitioner including any recommended spinal adjustments performed by a Chiropractor.

I intend this consent to apply to all my present and future care.

Dated this_____ day of_____, 20_____.

_____ **_____**

Patient Signature (or Legal Guardian) **Witness of Signature**

Name:_____ **Name:_____**

(please print) **(please print)**