FOR OFFICE USE ONLY:

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TUES	WED	THURS
GUEST		

- ☐ Dr. Justine Blainey-Broker, B.Sc., D.C.
- ☐ Dr. Blake Broker, B.Sc, D.C.
- ☐ Dr. Steve Gillis, BPE, ART, D.C.
- ☐ Dr. Stephanie Behmer, D.C.
- ☐ Other

Justine Blainey Wellness Centre

220 Wexford Road, Unit 2 Brampton, ON L6Z 4N7 (905) 840-WELL

Confidential Patient Case History

		DI
CE		
SUB		
X-RAY C/SP		
X-RAY T/SP		
X-RAY L/SP		
X-RAY OTHER		
GAIT		
TOTAL		

Name: _____ Age: _____ Today's Date: _____

Address: _____
Residence and Mailing City Province/State Postal Code/Zip

Home Telephone Number: _____

Work Telephone Number: _____ Cell Phone Number:_____

Email: _____ Birth date: _____ Male: __ Female:__

Occupation: _____ Employed by: _____

Single:____ Married: ___ Divorced:____ Widowed: ___ Partner's Name: _____

Number of children: _____ Names of children:

_____

Have you had previous chiropractic care? (circle one) Yes No Chiropractor's name: _____

Medical Doctor's name and phone number: _____

Who may we thank for referring you to our office?_____

Reason for Consulting our Office:

_____

Your Health Profile

Why This Form Is Important

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. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

Adult Years (Age 18 to present)

	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do/did you play any adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1-10 describe your stress level:
(1 = none, 10 = extreme)

Occupational: ____ Personal: _____

On a scale of 1-10, rate yourself on the following with 1 being poor and 10 being excellent:

Diet: ___/10 Exercise: ___/10 Sleep: ___/10 Mental Clarity/Focus: ___/10 General Health: ___/10

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Wellness Check up: Circle: Yes No

Specific Concerns:_____

_____

If you are experiencing pain, is it:

☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Radiating

Since the problem started, it is: ☐ About the Same ☐ Getting Better ☐ Getting Worse

What makes it worse?_____

How frequent is the complaint? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only

How long does it last? ☐ All day ☐ A Few Hours ☐ Minutes

Is there anything you can do to relieve the problem? ☐ Yes ☐ No If yes describe: _____

It Interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

0 1 2 3 4 5 6 7 8 9 10

Please mark an X on the line above to indicate your problem level

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem.

Headaches	Pins & Needles in Legs	Fainting	Neck Pain
☐ Pins & Needles in Arms	☐ Pins & Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Dizziness	☐ Loss of Smell	☐ Back Pain	☐ Loss of Balance
☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Fatigue	☐ Numbness in Toes	☐ Loss of Taste	☐ Upset Stomach
☐ Sleeping Problems	☐ Depression	☐ Irritability	☐ Tension
☐ Diarrhea	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Cold Sweats	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Mood Swings	☐ Sensitive Eyes	☐ Problem Urinating	☐ Heartburn
☐	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

Please note any major illnesses you have had: ☐ Heart disease ☐ Cancer ☐ Diabetes Other: _____

_____

Please list any major accidents or surgeries you have had: _____

_____

Please list any medications you are taking:_____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

	NAME(S):	Condition(s):
Children:		
Sister(s):		
Spouse:		
Mother:		
Father:		
Brother(s):		
Others:		

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Stress Test

When in your life did you experience any of the stresses listed below: C (child), T (teenager), A (adult), N (not at all)

I. PHYSICAL STRESS:

					Explain
Birth Trauma	C	T	A	N	
Slips/Falls	C	T	A	N	
Sports Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying Heavy Objects	C	T	A	N	
Repetitive Lifting/Bending	C	T	A	N	
Continuous Sitting/Standing	C	T	A	N	
Bone Fracture/Surgery	C	T	A	N	
Driving For Many Hours	C	T	A	N	
Car Accidents (How many? ____)	C	T	A	N	
Physical Abuse	C	T	A	N	
Work Injuries (How many? ____)	C	T	A	N	
Sleeping Position/Stomach	C	T	A	N	

II. CHEMICAL STRESS:

					Explain
Smoker – Amount? _____	C	T	A	N	
Second-Hand Smoke	C	T	A	N	
Poor Diet	C	T	A	N	
Caffeine – Amount? _____	C	T	A	N	
Excessive Sugar	C	T	A	N	
Artificial Sweeteners	C	T	A	N	
Prescription Drugs	C	T	A	N	
Over-The-Counter Drugs (Tylenol, Advil, etc.)	C	T	A	N	
Environmental Pollution (Air, Water, etc.)	C	T	A	N	

III. EMOTIONAL STRESS:

					Explain
Relationships	C	T	A	N	
Career	C	T	A	N	
Children	C	T	A	N	
Money	C	T	A	N	
Fast-Paced Life	C	T	A	N	
Internalized Feelings	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Sickness or Loss of a Loved One	C	T	A	N	
Quick Temper	C	T	A	N	
Verbal Abuse	C	T	A	N	

IV. WHICH DO YOU FEEL IS YOUR PRIMARY STRESS? ☐ PHYSICAL ☐ CHEMICAL OR ☐ EMOTIONAL?

Explain: _____

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www.blaineywellness.com

CONSENT FOR:
☐ Examination
☐ Adjustment
☐ Report of findings

CONSENT TO CHIROPRACTIC TREATMENT AND /OR EXAMINATION

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. Discuss forms of treatment with your doctor you are comfortable with.

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 in most severe cases only.

● 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.

- Consent to all encompassing chiropractic treatments knowing the Doctor(s) will discuss ahead of time them with me. (Example: Orthotics, change of techniques etc.)
- Consent to seeing another JBWC Doctor if/when needed. (Example: Time restrictions, scheduling, acute condition needing help and my primary Doctor is away etc.)
- I understand that the Justine Blainey Wellness Centre has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information.
- I understand that I may receive the following: newsletters, Thank you cards, Birthday cards, phone calls, health packages etc. that may be of interest to me.
- I hereby authorize the release of my medical/chiropractic records or copies of the same to such parties that the doctor may deem necessary as it relates to my case, and do hereby hold harmless anyone from such actions. This only occurs when patient asks in cases of emergency or for safety.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the examination and/or assessment of my condition and/or 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 and/or examination(s) as proposed to me.

_____	_____	_____
Patient Name (Please Print)	Signature of patient(or legal guardian)	Date
_____	_____	_____
Name of Chiropractor or Assistant	Signature of Chiropractor or Assistant	Date