Gaia Integrative Clinic
A division of 506703 NWT Ltd.
blending science and nature

Chiropractic Adult- Information and Consent Form

Please complete the following information in full:

Dr. Miss Mr. Mrs. Ms

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____

Suite/Apt./Unit No: _____

City: _____ Province: _____

Postal Code: _____

Gender: Male Female Date ofBirth: _____

Month / Day / Year

Work Phone:_____ Extension: _____

Home Phone:_____ Mobile Phone: _____

Fax Number:_____ Other Phone: _____

E-mail: _____

Preferred contact method: _____

May we leave a message? _____

Primary Practitioner: _____

Family Doctor

Name: _____ Phone Number: _____

Address: _____

Emergency Contact

Name: _____ Phone Number: _____

Relationship: _____

How did you hear about Gaia Integrative Clinic?

Referral Website Newspaper Yellow Pages Advertisement Friend/Family Other:____

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I, the undersigned, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. With this knowledge, I understand and acknowledge that I may ask questions regarding my treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement of my condition.

I hereby consent to the collection, use and/or disclosure of my personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to me. I further understand that my personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

_____

Patient's Name

_____ _____

Patient's Signature Date

P.O Box 1401, 4907-47th Street, Yellowknife, NT, X1A 2P1•Phone: 867-873-3669• Fax: 867-873-5642
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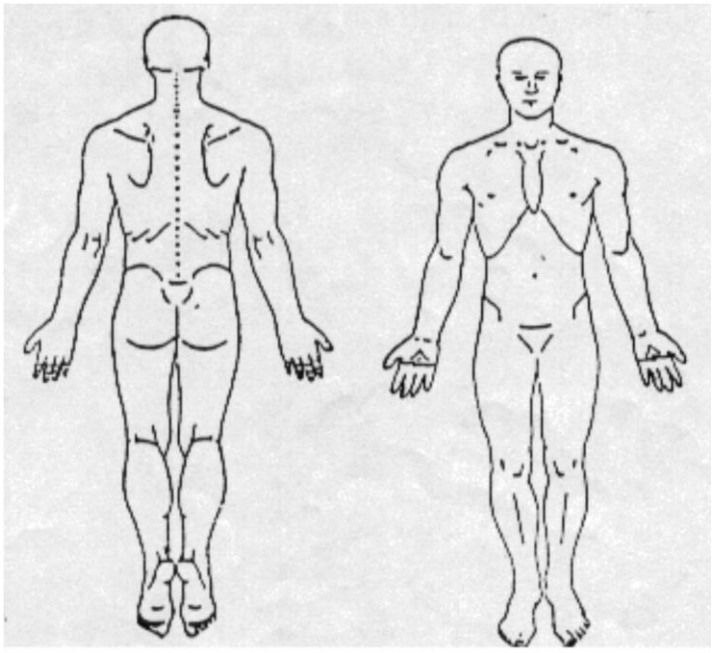
PATIENT INTAKE FORM

Is this your first time to a chiropractor? Yes No If not, when was your last visit: _____

MAIN COMPLAINT

Locate the area of pain using the following Symbols to describe your pain:



Legend:

++	Achy
**	Numbness
oo	Pins & Needles
xx	Stabbing/Sharp
//	Burning

TYPE OF INJURY

Is this is workplace injury (WSCC)? Yes No

Is this is motor vehicle accident (MVA) injury? Yes No

If you answered yes to one of these questions, give a 'brief' description of what happened and the injury you sustained.

_____

_____

_____

_____

What are your goals? _____

Date of Accident: _____

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Insurer or Employer Name: _____
Insurer or Employer Address and Phone: _____
Policy # or WSCC Claim #: _____

PERSONAL INFO

Past History ie: previous injuries, surgeries, or diagnosed health conditions

_____

_____

_____

Family History ie: heart attack, diabetes, stroke, psychological disorder, other hereditary condition

_____

_____

_____

Alcohol Intake?	Yes	No	If yes, how many drinks per day/week/month? _____
Do you smoke?	Yes	No	If yes, how many per day and for how long? _____
Drug Intake?	Yes	No	If yes, what do you take and how often? _____
Do you exercise?	Yes	No	If yes, what do you do, how often, and how long? _____

List any medications and/or supplements you are taking and the reason for taking them

_____

_____

_____

List Any Allergies

_____

_____

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Have you experienced any of the following symptoms in the past 3 months (circle all that applies):

Dizziness / Vertigo	Palpitations	Chest pain	Weight Gain / Loss
Nausea / Vomiting	Indigestion	Ringing in the ears	Depression
Loss of appetite	Insomnia	Itching	Anxiety / Nervousness
Shortness of breath	Fatigue	Diarrhea / Constipation	Double / Blurred vision
Loss of balance			

Females

Have you ever taken Birth Control Pill? Yes No If yes, when were you last on it, and what type are you taking?

_____

Are you currently pregnant? Yes No if yes, how far along are you and when are you due?

_____

Number of Pregnancies? _____
Number of children? _____

Males

Are you aware of any prostate problems? Yes No if yes, what is the problem and are you under treatment?

_____

I give the chiropractor/s (Dr. Lehman/ Dr. Bokor and any chiropractor who may work in their place) permission to perform a case history and physical examination in regards to my current exam. After the examination I understand the chiropractor will explain the findings to me, outline the risks and benefits and plan of management.

Permission to continue? Yes No

Patient Signature_____ Date _____

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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.

_____

Name (Please Print)

_____

Date:_____20____

Signature of patient (or legal guardian)

_____

Date:_____20____

Signature of Chiropractor