Dr. John Ahokas 26 Fead Street, Orangeville, ON L9W 1A8 (519) 941-2311

PATIENT ENTRANCE FORM

All answers are strictly confidential; Please print

Name_____ ❑ Male ❑ Female Date_____

Address_____City_____ Province_____

Postal Code_____ Home Phone_____ Cell Phone_____

Date of Birth_____Age _____ Marital Status_____

Employer Name and Address_____

Occupation _____ Work Phone Number_____

Emergency Contact _____Relationship_____

Emergency Contact Phone_____

Extended Health Care Company _____Policy # _____

How did you hear about our office (friend, physician, phone book) _____

PRIOR CHRIOPRACTIC CARE:

Name_____ Date of Last Treatment_____

Reason for Treatment_____

Results of Treatment: Excellent Good Fair Poor

MEDICAL DOCTOR:

Name_____Telephone_____

Date of Last Physical Exam_____

Results & Findings of Last Physical Exam_____

_____

_____

Date of last Dental Examination _____

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Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

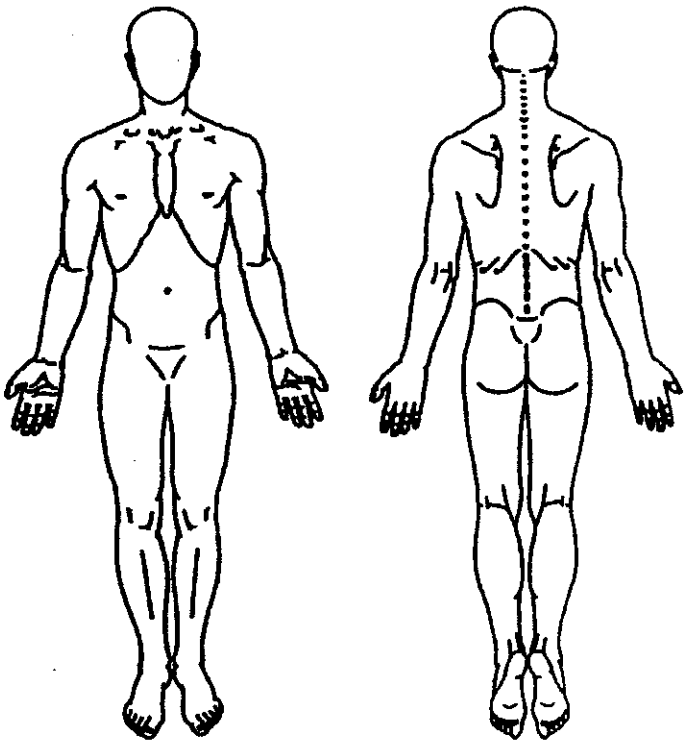
Numbness • • • • •
• • • • •
• • • • •

Pins & Needles 0 0 0 0 0
0 0 0 0 0
0 0 0 0 0

Burning X X X X X
X X X X X
X X X X X

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /
/ / / / /



Reason for consulting this office: _____

Expectations: _____

Have you ever had any of the following:

❑ aneurysm	❑ osteoporosis	❑ diabetes	❑ arthritis	❑ cancer	❑ heart conditions
❑ stroke	❑ allergies	❑ hepatitis	❑ "nerves"	❑ polio	❑ sinus conditions
❑ fatigue	❑ pneumonia	❑ pleurisy	❑ asthma	❑ ear infection	❑ respiratory condition
❑ V.D.	❑ psoriasis	❑ HIV	❑ depression	❑ hernia	❑ hemorrhoids
❑ sciatica	❑ varicose veins	❑ high blood pressure			
❑ diphtheria	❑ scarlet fever	❑ rheumatic fever	❑ chicken pox	❑ measles	❑ whooping cough

List all major illness and surgeries (that are not listed above), to the best of your ability; include your approximate age at the time of each

_____

_____

_____

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Please check the appropriate box if you have or recently have had any of the following:

❑ chills	❑ enlarged glands	❑ bruise easily	**For Women Only:**
❑ fevers	❑ enlarged thyroid	❑ jaundice	❑ irregular cycle
❑ sweats	❑ sore throat	❑ difficult digestion	❑ excessive menstrual flow
❑ weight loss	❑ eye pain	❑ stomach pain	❑ painful menstruation
❑ dizziness	❑ ear aches	❑ nausea	❑ vaginal discharge
❑ fainting	❑ deafness	❑ vomiting	
❑ headaches	❑ rapid heart beats	❑ diarrhea	
❑ tremors	❑ poor circulation	❑ constipation	Menopausal: ❑ Yes ❑ No
❑ swollen joints	❑ swelling of arteries	❑ frequent urination	
❑ foot trouble	❑ hardening of arteries	❑ painful urination	Pregnant: ❑ Yes ❑ No
❑ chest pain	❑ skin rash	❑ blood in urine	Due Date:_____
❑ difficulty breathing	❑ spitting blood	❑ prostate trouble	

Please list details for above_____

_____

Have you been previously hospitalized or knocked unconscious: ❑ Yes ❑ No If so, for how long:_____

Falls and Accidents (car, sports, work, etc..)_____

Please check if you have ever had any of the following tests:

❑ X-rays ❑ MRI ❑ CT Scan ❑ Blood ❑ Urine ❑ Other_____

Results of above tests:_____

List all medications, drugs, vitamins, minerals or herbal supplements you are currently taking:

_____

_____

Any family health conditions or problems (diabetes, cancer, stroke, heart disease..) ❑ Yes ❑ No

Please list: _____

_____

Do you have any congenital deformities (birth defects) that you know about: ❑ Yes ❑ No

If yes, please explain_____

Do you smoke: ❑ Yes ❑ No How much per day_____

Do you consume alcohol: ❑ Yes ❑ No How much per week_____

Do you exercise: ❑ Yes ❑ No List Activities & amount _____

_____

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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, casting/fitting for orthotics 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, including orthotics, as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor