Dr. Jabeen Jussa, B.Sc., D.C.
DOCTOR OF CHIROPRACTIC

MAINTAIN. RESTORE. ENHANCE

Thank you for choosing our clinic for your Chiropractic Needs. Please complete this form. If you have any questions, please feel free to ask.

Date: _____

PATIENT INFORMATION:

NAME_____ DATE OF BIRTH (M/D/Y) _____

ADDRESS _____

CITY_____ PROVINCE _____ POSTAL CODE _____

PHONE # Home_____ Mobile _____ Work _____

EMAIL ADDRESS _____ OCCUPATION _____

MEDICAL DOCTOR NAME _____ PHONE # _____

CARE CARD # _____ RECEIVE EMAIL NEWSLETTERS? (approx 5/year) Y N

HOW DID YOU HEAR ABOUT OUR CLINIC?

( ) Internet ( ) Building Signage ( ) Phone book ( ) Brochure

( ) Friend _____ ( ) Work Colleague _____

( ) Medical Doctor _____ ( ) Family Member _____

( ) Massage Therapist _____ ( ) Physiotherapist _____

( ) Chiropractor _____ ( ) Other _____

Do you have extended health care insurance? Yes No If yes, with whom? _____

Have you received Chiropractic Care previously? Yes No
Reason for past Chiropractic Care _____
Results: Excellent Good Fair Poor

ARE YOU CLAIMING?

Worker Compensation Board Yes No Claim #_____ Adjustors Name: _____
I.C.B.C Yes No Claim #_____ Adjustors Name: _____

OTHER HEALTH CARE PRACTITIONERS TREATING YOU?

( ) Massage Therapy ( ) Acupuncture ( ) Physiotherapy ( ) Naturopathic Doctor
( ) Other: _____

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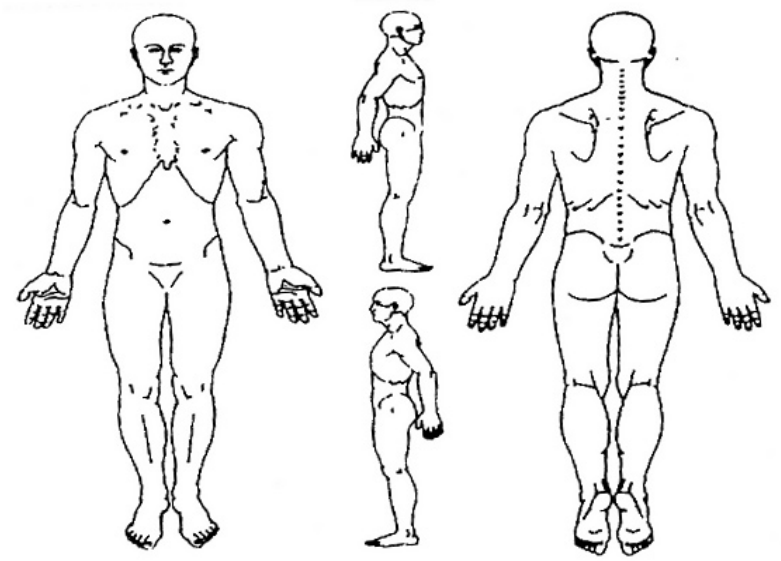
Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A = Ache
B = Burning
N = Numbness
O = Other
P = Pins & Needles
S = Stabbing



REASON(S) FOR TODAYS VISIT:

_____

_____

_____

_____

Are your symptoms changing?

( ) Improving

( ) Not Changing

( ) Getting Worse

Have you undergone any surgeries? Yes No If yes, briefly describe

_____

Have you ever had any falls, injuries, car accident, traumas, head injuries, accidents? Yes No
Describe_____

_____

Are you currently taking any medications (prescription or over the counter) Yes No

List: _____

Are you currently taking any vitamins, minerals or herbal supplements Yes No

List:_____

When was your last physical exam? _____

Do you currently wear Custom – made Orthotics? Yes No If yes, how old are they? _____

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For Women:

Menstrual Problems: Yes No If yes, describe _____

Are you pregnant: Yes No If yes, expected due date _____

Please mark with a "√" if you are currently experiencing or have experienced any of the following:

( ) headaches
( ) neck pain
( ) jaw pain
( ) pain between shoulders
( ) low back pain
( ) sinusitis
( ) stroke
( ) dizziness
( ) nausea
( ) loss of vision
( ) loss of taste/smell
( ) fainting spells
( ) loss of consciousness
( ) high/low blood pressure
( ) arthritis
( ) allergies
( ) asthma
( ) shortness of breath
( ) pinched nerve
( ) general fatigue
( ) depression
( ) slipped disc
( ) difficulty swallowing
( ) anemia
( ) visual problems
( ) ear infections
( ) cold hands/feet
( ) stomach pain
( ) heart burn/indigestion
( ) loss of memory
( ) bladder infections
( ) ulcers
( ) prostate problems
( ) blood disorders
( ) diabetes
( ) cancer
( ) HIV/AIDS
( ) Thyroid Problems
( ) sciatica
( ) hay fever
( ) migraines
( ) neck spasms
( ) loss of weight
( ) night sweats
( ) clicking in neck
( ) liver trouble
( ) excessive gas
( ) gall bladder stones
( ) painful urination
( ) rheumatoid arthritis
( ) aortic aneurysm
( ) diarrhea
( ) constipation
( ) kidney problems
( ) chest pain
( ) heart attacks

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CHIROPRACTIC CHIROPRATIQUE Canada

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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

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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