calgary family wellness
Courtesy of Dr. Shanna Rai (403) 452-9544

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Date: _____

Patient Information

First Name: _____M.I:_____ Last Name: _____

Preferred Name: _____

Address: _____

City/Province/Postal Code: _____

Birth Date (mm/dd/yyyy) :_____ Age: _____ Sex: M F

Home Phone:_____ Cell Phone: _____

Email: _____

Occupation: _____ Employer's Name:_____

Marital Status □ Married □ Common Law □ Single □ Widowed □ Divorced

Spouse's Name:_____ Name of Children:_____

Emergency Contact:_____ Phone: _____

Email: _____

How did you hear about Calgary Family Wellness?:_____

Reason for Seeking Care

What is your reason for seeking care at Calgary Family Wellness?
Primary:_____Secondary:_____

How long have you had this? How would you describe the pain?	sharp dull/achy burn pins/needles	sharp dull/achy burn pins/needles
How would you rate the pain? (0 no pain at all – 10 worst pain)	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
How often does this happen?	constant on / off daily	constant on / off daily
What makes it worse? (sitting, standing etc.) What have you tried to address this concern?		
At its' worst, this problem interferes with:	ability to work hobbies/sports family/social time sleep daily activities	ability to work hobbies/sports family/social time sleep daily activities
Is this a work related injury?	Y / N	Y / N

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10
If you don't get the problem corrected, do you think it will get worse in the next:

1 year__ 2 years__ 5 years__

Explain: _____

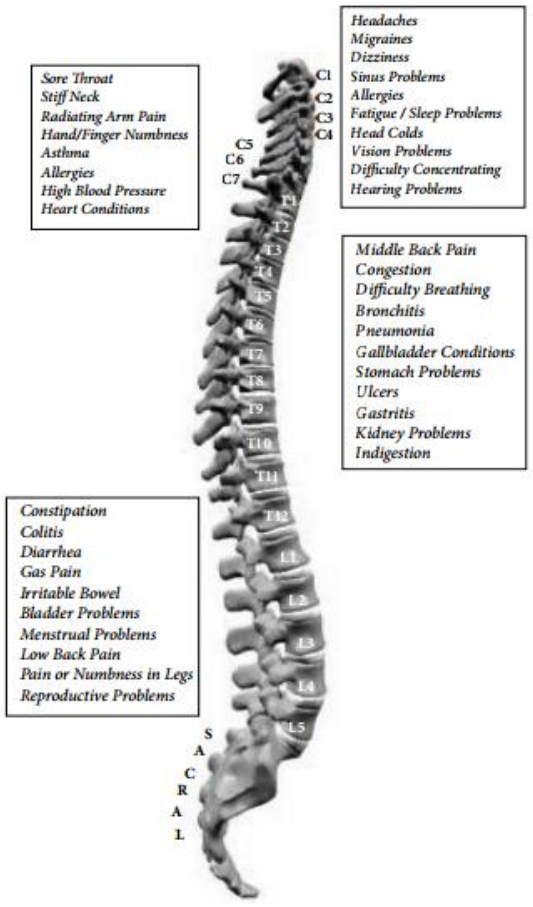
What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

_____

Did you know? Each Health concern relates to a specific area of the spine and nervous system?
Please enter the information to the left

Health Concerns	
Body Pain	
❑ Tension/Headaches	❑ Deafness/ears ringing
❑ Ear aches/infections	❑ Blurred/Failed vision
❑ Pain between shoulders	❑ Tension across tops of shoulders
❑ Neck Pain	❑ Numbness/tingling in arms/hands
❑ Wrist/hand pain	❑ Mid back pain
❑ Low back pain	❑ Hip pain
❑ Chest pain	❑ Numbness/tingling in legs/feet
❑ Knee pain	❑ Foot pain
Symptoms/Conditions	
❑ Bladder problems	❑ Thyroids problems
❑ Weight trouble	❑ Breathing problems
❑ Asthma	❑ Immune problems
❑ Frequent colds/flus	❑ Heart problems
❑ Heartburn	❑ Shin Splints
❑ High Blood Pressure/Low	❑ Arthritis/swollen joints
❑ Shin splints	❑ Difficulty sleeping
❑ Anxiety Depression	❑ Elevated Cholesterol
❑ Allergies/Infections	❑ ADD/ADHD
❑ Poor concentration/memory	❑ Digestive problems
❑ Sexual Dysfunction	❑ Dizziness
❑ Ulcer	❑ Infertility
❑ Diabetes	❑ Cancer



Women Only

- ❑ Pregnant
- ❑ Excessive cramping
- ❑ Hot flashes
- ❑ Excessive menstruation
- ❑ Breast pain/lumps
- ❑ Irregular Cycle

Date of last menstrual cycle ___/___/_____

- ❑ Explain any boxes checked

  _____

  _____

- ❑ Is there anything else regarding your current condition you feel the Doctor should know?_____

Traumas and Stress

In your whole life, what were your 5 most serious physical traumas/stresses (e.g. automobile jarring/impacts, work stress, recreational activities, sports, falls and fractures)

Traumas	Date of Trauma	Office Use
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Vitamins & Supplements & Medications

❑ Probiotics	❑ Pain Narcotics
❑ Omega-3	❑ Antibiotics
❑ Vitamin D-3	❑ Anti-inflammatory
❑ Digestive Aids	❑ Migraine medication
❑ Multi-vitamin	❑ Asthma medication

❑ Other_____

Explain any checked boxes_____

_____

Health Status Questionnaire

Your Physical Life

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Presence of physical pain	1 2 3 4 5	Incidence of colds or flu	1 2 3 4 5
Feelings of tension, stiffness, lack of flexibility	1 2 3 4 5	Ability to work out or engage in activity	1 2 3 4 5
Incidence of fatigue or low energy	1 2 3 4 5	Incidence of chronic disease	1 2 3 4 5

Mental/Emotional State

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Presence of negative feelings/energy	1 2 3 4 5	Being overly worried about small things	1 2 3 4 5
Moodiness, temper or angry outbursts	1 2 3 4 5	Difficulty thinking or concentrating	1 2 3 4 5
Difficulty falling or staying asleep	1 2 3 4 5	Feeling of depression or anxiety	1 2 3 4 5

Chemical/Nutritional Life

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Eat a well-balanced diet	1 2 3 4 5	Eat organic, grass fed, hormone free	1 2 3 4 5
Eat a diet rich in fruit and vegetables	1 2 3 4 5	Use a lot of chemicals on skin	1 2 3 4 5
Eat fast food or highly processed food	1 2 3 4 5	Injection of chemicals	1 2 3 4 5

Stress Evaluation

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Family	1 2 3 4 5	Work/School	1 2 3 4 5
Significant relationship	1 2 3 4 5	Day-to-day stress	1 2 3 4 5
Health	1 2 3 4 5	Finances	1 2 3 4 5

Life Enjoyment

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Experiences of relaxation, ease, or well-being	1 2 3 4 5	Compassion and acceptance	1 2 3 4 5
Interest in maintaining a healthy lifestyle, diet, etc.	1 2 3 4 5	The level of recreation in your life	1 2 3 4 5
Time devoted to things you enjoy	1 2 3 4 5	Your physical appearance	1 2 3 4 5

What else about your health or your life do you feel is important for the doctor to know?

_____

_____

Terms and Acceptance

When a person seeks chiropractic health care and when a chiropractor accepts a person for such care, it is essential that both are speaking and working for the same goal. The primary goal of chiropractic is

TO LOCATE, ANALYZE, AND CORRECT
SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote health.

I hereby request and consent to the performance of chiropractic procedures including diagnostic x-rays, if necessary, on me by Dr. Shanna Rai and/or anyone working in this clinic authorized by Dr. Shanna Rai.

I will have an opportunity to discuss with the doctor and/or staff, the nature and purpose of chiropractic adjustments and other procedures, as well as any questions I have regarding specific technique performed. I understand that the results expected are not guaranteed, as every person is unique.

I further understand and am informed that, as in all health care, in the practice of manipulation by medical doctors, physiotherapists and chiropractors that there are some very slight and minimal risks to care, including, but not limited to:
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 have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of present and future care.

I understand that the purpose of today's visit is to determine if I am a candidate for chiropractic care and that I am responsible for any fees agreed upon between myself and the attending doctor. All examination fees will be explained to me before any tests are performed.

_____ _____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) | PRINT PATIENT'S NAME

_____ _____

DATE SIGNED | WITNESS