Dr. Jason N. Guben, Chiropractor DC

Prénom/First Name_____ Nom/Last Name_____ Age___ Sexe : M☐F☐

Adresse_____ Apt._____ Ville/City_____

Code Postal Code_____ Tel.(Rés-H) _____ Tel. (Bur-O) _____ext._____

Tel. cell._____ Date de Naissance/Date of Birth: **an/yr_____ms/mm _____jr/dd_____**

Occupation_____ Courriel/e-mail _____

Statut Civil/ Marital Status_____ Nom du Conjoint(e) / Spouse's Name _____

Qui vous a recommandé à notre bureau ? Ami(e) / Friend ☐ Enseigne / Outside Sign ☐ Conjointe(e) / Spouse ☐
Who recommended you to our office? Autre/ Other ☐ Nom / Name _____

Avez-vous déjà consulté un Chiropraticien? Oui /Yes ☐ Non / No ☐ Qui/ Who_____
Have you ever seen a chiropractor? Quand / When _____

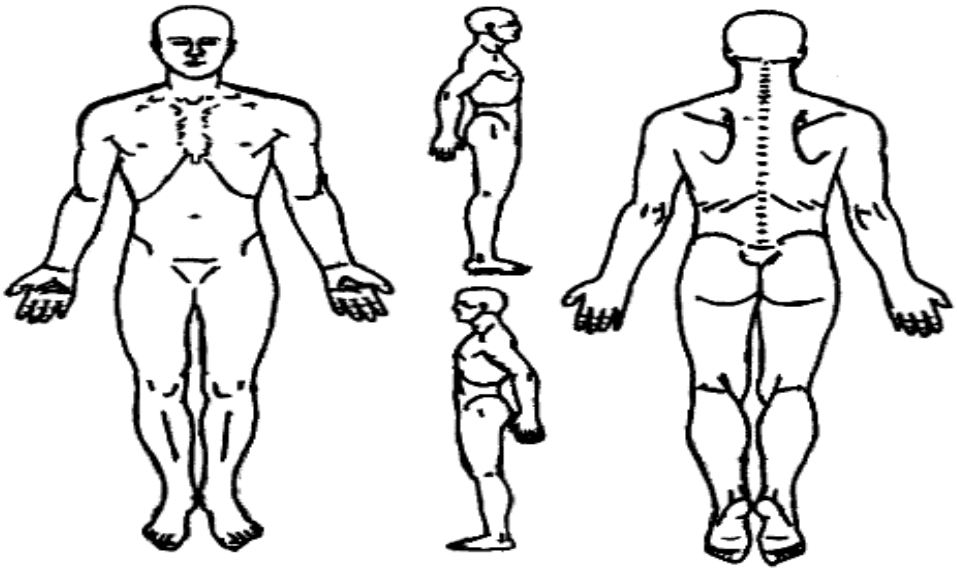
Avez-vous une assurance qui couvre les soins chiropratiques? Oui / Yes ☐ Non / No ☐ ? ☐
Do you have insurance that covers chiropractic care?

Médecin de Famille / Family Doctor_____ Address_____

Date du dernier examen / Date of Last Physical Examination _____ / _____ / _____

Veuillez indiquer, sur le schéma les endroits exacts de vos douleurs.
Please indicate on the drawing, the exact location of your problems.

Numbness / Engourdissement ●●●● Burning / Brûlement xxxx
Pins + Needles / Picotement **** Stiff + Tight / Raideur 2222
Stabbing-Sharp / Aigue (Couteau) //// Aching / Sourde ++++



Quelle est la raison de votre consultation? Veuillez indiquer vos problèmes de santé par ordre d'importance. _____

_____

_____

_____

What is the reason for your consultation? Please list your health problems in order of importance. _____

_____

_____

_____

Depuis / Since_____

_____

Empirer : Pencher S'Asseoir / Se Lever Tenir Debout Marcher Couche
AM / durant la journée / PM Sans Bouger / Avec Mouvement

Améliorer: Pencher S'Asseoir / Se Lever Tenir Debout Marcher Couche
AM / durant la journée / PM Sans Bouger / Avec Mouvement

Worsen : Bending Sitting / Rising Standing Walking Lying
AM / as the day progresses / PM When Still / on the move

Better: Bending Sitting / Rising Standing Walking Lying
AM / as the day progresses / PM When Still / on the move

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Centre de Soulagement de la Douleur — Pain Relief Center

Association des chiropraticiens du Québec

1. Cochez la case qui correspond à la sévérité de votre douleur principale.

DOULEUR HABITUELLE

Pas de Douleur — Douleur Extrême

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

DOULEUR MAINTENANT

Pas de Douleur — Douleur Extrême

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

2. Prenez-vous de médicaments de façon régulière?

Oui ☐ Non ☐

Si Oui, lesquels? (Coumadine, Heparin, Plavix, Aspirine, Contre le Hypertension Artérielle etc.)

_____

_____

3. Avez-vous déjà souffert des conditions suivantes :

Anévrisme ☐	Ostéoporose ☐	Diabète ☐
Cancer ☐	Migraines ☐	Mal de Tête ☐
Fatigue ☐	Asthme ☐	Arthrite ☐
Psoriasis ☐	Étourdisement ☐	Perte de Poids ☐
Hypertension ☐	Accident Cérébro-Vasculaire ☐	
Épilepsie ☐	Trouble du Système Nerveux ☐	
Goutte ☐	Problèmes Respiratoires ☐	
Insomnie ☐	Problèmes Cardiaques ☐	
Dépression ☐	Arthrite Rhumatoïde ☐	
Convulsions ☐	Problèmes de Sinus ☐	
Picotement ☐	Perte de Conscience ☐	

4. Avez-vous déjà subi une fracture? Oui ☐ Non ☐

_____

5. Avez-vous déjà été victime d'un accident d'auto?
Oui ☐ Non ☐ _____

6. Avez-vous déjà été hospitalisé(e) ? Oui ☐ Non ☐

_____

7. Fumez-vous présentement? Oui ☐ Non ☐

8. Avez-vous déjà fumé? Oui ☐ Non ☐ Quand_____

9. Avez-vous des allergies? Oui ☐ Non ☐ Si oui, lesquels _____

10. Avez-vous déjà pris des contraceptions oraux?
Présentement / Antérieurement / Jamais

11. # De Grossesse(s) _____ # D'Enfant(s) _____

1. Check the box that indicates the severity of your main problem.

USUAL LEVEL OF PAIN

No Pain — Extreme pain

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

PRESENT LEVEL OF PAIN

No Pain — Extreme pain

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

2. Are you currently taking any medication on a regular basis? Yes ☐ No ☐

If Yes, What: (Coumadine, Heparin, Plavix, Aspirin, Antihypertensive etc.

_____

_____

3. Have you ever had any of the following conditions:

Aneurysm ☐	Osteoporosis ☐	Diabetes ☐
Cancer ☐	Migraines ☐	Headaches ☐
Fatigue ☐	Asthma ☐	Arthritis ☐
Psoriasis ☐	Dizziness ☐	Weight Loss ☐
Hypertension ☐	Stroke ☐	
Epilepsy ☐	Nervous System Disorder ☐	
Gout ☐	Respiratory Problems ☐	
Insomnia ☐	Heart Conditions ☐	
Depression ☐	Rheumatoid Arthritis ☐	
Convulsions ☐	Sinus Problems ☐	
Tingling ☐	Loss of Consciousness ☐	

4. Have you ever had any fractures? Yes ☐ No ☐

_____

5. Have you ever been in a car accident?
Yes ☐ No ☐ _____

6. Have you ever been hospitalised? Yes ☐ No ☐

_____

7. Do you smoke? Yes ☐ No ☐

8. Have you smoked in the past? Yes ☐ No ☐ When_____

9. Do you have any allergies? Yes ☐ No ☐ If yes, to what _____

10. Have you ever been on birth control pills?
Currently / Previously / Never

11. # Of Pregnancies _____ # Of Children ____

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

I UNDERSTAND THAT IN THE EVENT OF A CANCELLATION, I MUST NOTIFY THE OFFICE 24 HOURS IN ADVANCE. IF NOT A PENALTY FOR THE FULL COST OF THE TREATMENT WILL BE CHARGED

◯ I consent to receive follow-up email and correspondence by email as per the Canadian Anti-spam law (CASL)