Appointment Date: _____

Patient Intake Form

Last name:_____First name:_____ M / F
Address:_____City: _____Prov._____
Postal code :_____Phone (home): _____ work: _____
cell: _____E-mail: _____
Date of birth (d/m/y) _____ # Of Children: _____ Occupation: _____

☐ I hereby give my consent to Source Centre to contact me via e-mail or to leave phone messages regarding my care at the above numbers.
Family Doctor: _____Doctor's Address _____

☐ I hereby give my consent to Dr. Sutherland to inform my family Doctor that I am under her care.
patient signature_____ date_____
How did you discover our office and the professional services we offer?_____
_____

Your Health Concerns or Symptoms and How They May Affect Your Life

Do you have a current health concern? Please describe:_____
_____
When did this situation or concern begin?_____
Have you done anything about this situation or gotten any advice or treatment for it? Yes ☐ No ☐
If yes, what were you told? _____
What was done? _____
Did it seem to work? _____

Please grade the level to which this health concern affects these aspects of your life
X = does not affect me ✓= affects me somewhat
✓✓ = affects me moderately ✓✓✓ = affects me drastically

___effect on work	___effect on recreation/play	___effect on rest/sleep
___effect on social life	___effect on walking	___effect on sleeping
___effect on exercise	___effect on eating	___effect on love life
___concern about particular symptom/condition		___concern about health
___ effect during the daytime	___effect at nighttime	

Is there anything that makes this concern worse?_____
Is there anything that makes this concern better?_____
Why do you think this is happening or continues to happen to you? _____
If this symptom were to go away tomorrow what would be different about your life? _____
_____
What are you doing in your life now that is different than if you did not have this concern?
_____
Please mark the statement that you feel best describes your current feelings about yourself and your situation.
☐ I feel helpless, like little or nothing works
☐ I feel terrible, really bad, I am scared, and hope that you can fix me.
☐ I feel stuck, and I can't help myself right now.
☐I deserve more than what I've been experiencing, and would like you to assist me in my healing.

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Source Centre for Health and Wellness
2 King St E, Stoney Creek, ON L8G1J8

Physical History

Each of these has potential to stress your nervous system. Please indicate which plays a role in your life either presently or in the past.

	Mild		Moderate		Extreme	
	Past	Present	Past	Present	Past	Present
Falls	☐	☐	☐	☐	☐	☐
Sports impacts	☐	☐	☐	☐	☐	☐
Physical fights	☐	☐	☐	☐	☐	☐
Physical/sexual abuse	☐	☐	☐	☐	☐	☐
Repeated postural stress	☐	☐	☐	☐	☐	☐
Childhood injuries/Falls	☐	☐	☐	☐	☐	☐
Motor Vehicle Accidents	☐	☐	☐	☐	☐	☐

Please check yes or no to the following questions. If you check yes, please explain.
Have you ever been knocked unconscious? Yes☐ no ☐ _____
Have you ever used crutches, a cane or a walker? Yes ☐ no ☐ _____
Have you ever broken any bones? Yes ☐ No ☐ _____
Have you ever had an impact, fall or jolt that may have injured your spine? Yes ☐ No ☐_____
_____
Have you ever been hospitalized? Yes ☐ No ☐ _____
Have you had surgery? Yes ☐ No ☐ _____

Have you had? ☐ Spinal x-rays ☐ Cat scans ☐ MRI imaging ☐ Spinal brace ☐ Neck collar
☐ Heel lift ☐ Orthotics ☐ Traction ☐ Spinal Tap ☐ Traction

During the day do you sit ☐ stand ☐ Do phone work ☐ do deskwork ☐
drive ☐ walk ☐ mechanical work ☐ heavy lifting ☐

Chemical History

Please grade any dietary selection that is appropriate for you using the following scale
X = do not consume this
✓= consume this rarely
✓✓ = consume this weekly
✓✓✓ = consume this daily or more

___alcohol	___fried foods	___beef
___coffee	___cooked, canned vegetables	___poultry
___tobacco	___dairy (milk products)	___fish
___artificial sweeteners	___eggs	___seafood
___soft drinks	___whole grains	___fasting
___diet food	___fruit	___organic foods
___refined sugar	___raw vegetables	___vitamins/ supplements

Do you or did you work with any chemical, fume, dust, powder, smoke etc. for long periods?
Please list any medications you are presently using _____
_____
Please list any herbs, nutritional supplements or natural remedies you take regularly_____
_____

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Emotional History

	Mild		Moderate		Extreme	
	Past	Present	past	present	past	present
Childhood stress	☐	☐	☐	☐	☐	☐
School stress	☐	☐	☐	☐	☐	☐
Family stress	☐	☐	☐	☐	☐	☐
Relationship stress	☐	☐	☐	☐	☐	☐
Stress of being sick	☐	☐	☐	☐	☐	☐
Stress of a loved one being sick	☐	☐	☐	☐	☐	☐
Work related stress	☐	☐	☐	☐	☐	☐
Stress of commuting	☐	☐	☐	☐	☐	☐
Loss of a loved one	☐	☐	☐	☐	☐	☐
Change in life-style	☐	☐	☐	☐	☐	☐
Change in career	☐	☐	☐	☐	☐	☐
Abuse(emotional/physical/sexual)	☐	☐	☐	☐	☐	☐

Is there some aspect of your life that very much pleases you, brings you joy, or helps you to feel better about yourself?_____
When you are stressed, how do you "Center" yourself or "Re group" ?_____
_____

Previous Therapeutic Modalities

Have you had experience with any of the following health, treatment or healing modalities? If so, please describe when you went, for how long you went and the results:

☐Ayervedic medicine_____
☐ Bodywork/ Massage_____
☐ Breathwork _____
☐ Emotional Therapy/ Psychotherapy_____
☐ Homeopathy/ Herbalist _____
☐ Meditation/ Prayer _____
☐ Movement/ Exercise_____
☐ Music/ Sound/ Light/ Aromatherapy _____
☐ Nutritional Counseling/ Therapy_____
☐ Oriental Medicine/ Acupuncture_____
☐ Osteopathy/ Cranial Work _____
☐ Somato Respiratory Integration_____
☐ Yoga/ Movement/ Dance/ Tai Chi/ Chi Gong _____
☐ Other: _____

Has your spine ever been professionally adjusted? Yes ☐ No ☐
How long ago? And by whom? _____
Why did you go?_____
Are you still going?_____
Were you pleased?_____
Does your family receive Chiropractic care?_____

What would motivate you to tell others about the care you receive in this office, and encourage others to receive care?_____

Informed Consent to Wholistic Spinal Care

Dr. Sutherland practices Wholistic Spinal Care, a unique approach to caring for you as a whole person. Dr. Sutherland utilizes Network Spinal Analysis (NSA), a safe and gentle chiropractic technique consisting of gentle manual contacts along the spinal tissues. NSA enables the nervous system to release stored tension, enhancing your body's ability to heal itself.

I hereby request and consent to the performance of Wholistic Spinal Care and other chiropractic procedures, on me, by Dr. Sutherland . I also understand that the results of such treatment are not guaranteed.

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatments. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques.
b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present scientific and medical evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Due to the utilization of other gentle methods, Dr. Sutherland will ask for your consent if manual adjustments are required.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I have read the above consent. I have had the opportunity to ask questions about its content, and by signing below, I agree to the included procedures. I intend this Consent to cover the entire course of my treatment plan.

Dated this _____ day of _____ 20 _____.

_____ _____

Signature of Patient (or legal guardian) **Signature of Witness**

_____ _____

Name of Patient (please print) **Name of Witness (please print)**

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