



Dr. Mark Guker  
Dr. Phil Sammut  
2040 Eagle St N  
Cambridge, Ontario N3H0A1  
(519) 650-1630 www.realignhealth.com

**Patient Information**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone (Cell) \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F  
Marital Status M W D S Occupation/Employer \_\_\_\_\_ Phone  
(Work) \_\_\_\_\_  
Email \_\_\_\_\_

Extended Health Insurance Company \_\_\_\_\_  
Present condition due to an injury?  Yes  No  On the Job  Auto Accident  Other  
\_\_\_\_\_  
Has the accident been reported?  Yes  No  To Employer  Auto Carrier  Other  
\_\_\_\_\_

**HEALTH REPORT:**

Reasons for seeking care: (in order of severity)  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

List any other types of doctors that you have seen for this:  
\_\_\_\_\_

List any diagnosis and type of treatment: \_\_\_\_\_  
Have you had similar accidents or injuries before?  Yes  No If yes, explain:  
\_\_\_\_\_

Have you received chiropractic treatment previously?  Yes  No  
If yes, explain: \_\_\_\_\_  
Have you been treated for any health condition by a physician in the last year?  Yes  No  
If yes, explain: \_\_\_\_\_

Are you currently taking medication?  Yes  No list medications:  
\_\_\_\_\_  
\_\_\_\_\_

Have you taken medication in the past?  Yes  No list medications  
\_\_\_\_\_

List conditions you are taking medications for:  
\_\_\_\_\_

List the approximate dates of any surgery or treated  
conditions: \_\_\_\_\_  
\_\_\_\_\_



Patient Name: \_\_\_\_\_

Family History: Health conditions, age of death and cause of death.

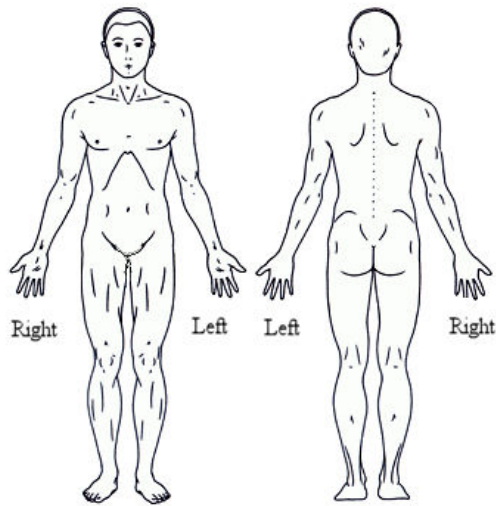
Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brother/s & Sister/s: \_\_\_\_\_

Do you smoke Y/N \_\_\_ •Alcohol Y/N \_Daily \_Weekly \_Social Occasions •Caffeinated drinks per day \_\_\_

Do you take Vitamins/Supplements Y/N If yes, type and how often  
\_\_\_\_\_



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness = = =

Dull Ache 000

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other \_\_\_\_\_ ^ ^ ^

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your

condition/pain? \_\_\_\_\_

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with Work? \_\_\_\_\_

Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_

Is this condition progressively getting worse? \_\_\_\_\_  
\_\_\_\_\_



Patient Name: \_\_\_\_\_

Please mark each item below for each sign or symptom you presently have or previously had:

**GENERAL SYMPTOMS**

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

**MUSCLES & JOINTS**

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

**CARDIO-VASCULAR**

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

**EAR/NOSE/THROAT**

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

**GASTRO-INTESTINAL**

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

**RESPIRATORY**

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

**GENITO-URINARY**

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

**SKIN OR ALLERGIES**

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy \_\_\_\_\_

**FOR WOMEN ONLY**

- Birth Control \_\_\_\_\_
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.  
I agree to allow this office to examine me for further evaluation.

Patient  
Signature \_\_\_\_\_ Date \_\_\_\_\_



## **Intake Questionnaire**

**How would you rate your overall level of pain?**

10 (most) 9 8 7 6 5 4 3 2 1 (least)

**How would you rate your overall level of happiness at home?**

10 (most) 9 8 7 6 5 4 3 2 1 (least)

**How would you rate your overall level of happiness at work?**

10 (most) 9 8 7 6 5 4 3 2 1 (least)

**What are the 3 biggest stressors in your life right now?**

i)

ii)

iii)



## 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

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.**

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

Date: \_\_\_\_\_ 20\_\_\_\_.