

DR. ALEX RITZA ~ CHIROPRACTOR

28 PARK ROAD, TORONTO, ONTARIO, M4W 1M1 ~ TEL (416) 920-7275 FAX (416) 920-7274

UPDATED PATIENT INFORMATION

Please fill in your name and other information that may need to be changed or updated in our files.

Today's Date (dd/mm/yy)

Last Name

First Name

Apt # Address

City

Province

Postal Code

Home Phone

Cell Phone

E-Mail Address

Emergency Contact Name

Emergency Contact's Phone

Your Occupation and Employer

Work Phone

May we contact you at work? Yes No

Your preferred method of contact:

Home Phone Cell Phone E-mail

Work Phone

Medical doctor's name

Medical doctor's phone or address

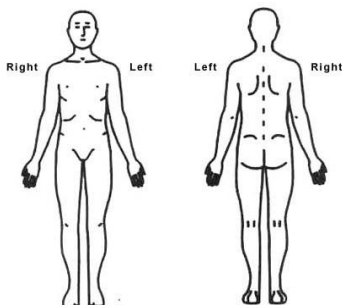
UPDATED PATIENT HISTORY

Please select one:

- Progress evaluation** I've been under active care and this is a periodic re-evaluation.
- New Condition** I've been under care and a new or returning condition has emerged.
- Maintenance Patient** I'm under maintenance care with a new or returning health issue.
- Returning Patient** After a period of inactivity, I've had a relapse or an all-new health issue.

1. Current symptoms:

2. Location (Where does it hurt?)



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3. Quality of Symptoms (What does it feel like?)

- | | | |
|---------------------------------|-------------------------------|-----------------------------------|
| <input type="radio"/> Numbness | <input type="radio"/> Aching | <input type="radio"/> Burning |
| <input type="radio"/> Tingling | <input type="radio"/> Cramps | <input type="radio"/> Shooting |
| <input type="radio"/> Stiffness | <input type="radio"/> Nagging | <input type="radio"/> Stabbing |
| <input type="radio"/> Dull | <input type="radio"/> Sharp | <input type="radio"/> Other _____ |

4. Intensity (How extreme are your current symptoms?)

0 { } 10
{Absent Uncomfortable Agonizing}

5. Duration and Timing (When did it start and how often are your current symptoms?)

_____ Constant Comes and goes

6. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel?)

7. Aggravating or relief factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

8. Prior interventions (What have you done to relieve the symptoms?)

- | | | |
|---|------------------------------------|------------------------------------|
| <input type="radio"/> Prescription medication | <input type="radio"/> Surgery | <input type="radio"/> Ice |
| <input type="radio"/> Over the counter drugs | <input type="radio"/> Acupuncture | <input type="radio"/> Heat |
| <input type="radio"/> Homeopathic remedies | <input type="radio"/> Chiropractic | <input type="radio"/> Others _____ |
| <input type="radio"/> Physiotherapy | <input type="radio"/> Massage | |

9. Is this a work related or motor vehicle accident related injury? Yes No

10. Have you had x-rays taken? Yes No

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11. Review of systems (Identify changes since your most recent evaluation with us): **Worse No Change Improved**

- a. **Musculoskeletal System**- osteoporosis, arthritis, neck and back pain, poor posture, etc. -----⊙-----⊙-----⊙
- b. **Neurological System**- anxiety, depression, headaches, dizziness, pins and needles, etc. -----⊙-----⊙-----⊙
- c. **Cardiovascular System**- high or low blood pressure, high cholesterol, angina, etc. -----⊙-----⊙-----⊙
- d. **Respiratory System**- asthma, apnea, emphysema, hay fever, shortness of breath, etc. -----⊙-----⊙-----⊙
- e. **Digestive System**- anorexia/bulimia, ulcer, food sensitivities, diarrhea, indigestion, etc. -----⊙-----⊙-----⊙
- f. **Sensory System**- blurred vision, ringing in ears, hearing loss, chronic ear infections, etc. -----⊙-----⊙-----⊙
- g. **Skin System**- skin cancer, psoriasis, eczema, acne, hair loss, rash, etc. -----⊙-----⊙-----⊙
- h. **Endocrine System**- thyroid issues, immune disorders, hypoglycemia, frequent urination, etc. -----⊙-----⊙-----⊙
- i. **Genitourinary System**- kidney stones, infertility, bedwetting, prostate issues, PMS, etc. -----⊙-----⊙-----⊙
- j. **Constitutional System**- fainting, low libido, poor appetite, fatigue, sudden weight, etc. -----⊙-----⊙-----⊙

12. Illnesses, operations, injuries or treatments since your most recent visit?

13. What else should Dr. Ritza know about your current condition?

14. Medications and supplements (please list ALL prescription, over-the-counter-drugs and supplements/vitamins):

15. Social History (Tell Dr. Dower about your health and stress levels.)

- | | | | |
|----------------|-----------------------------|------------------------------|-----------------|
| Alcohol use | <input type="radio"/> Daily | <input type="radio"/> Weekly | How much? _____ |
| Caffeine use | <input type="radio"/> Daily | <input type="radio"/> Weekly | How much? _____ |
| Tobacco use | <input type="radio"/> Daily | <input type="radio"/> Weekly | How much? _____ |
| Exercising | <input type="radio"/> Daily | <input type="radio"/> Weekly | How much? _____ |
| Pain relievers | <input type="radio"/> Daily | <input type="radio"/> Weekly | How much? _____ |
| Soft drinks | <input type="radio"/> Daily | <input type="radio"/> Weekly | How much? _____ |
| Water intake | <input type="radio"/> Daily | | How much? _____ |

Hobbies: _____

- | | | |
|----------------------|---------------------------|--------------------------|
| Meditation? | <input type="radio"/> Yes | <input type="radio"/> No |
| Yoga? | <input type="radio"/> Yes | <input type="radio"/> No |
| Job pressure/stress? | <input type="radio"/> Yes | <input type="radio"/> No |
| Financial peace? | <input type="radio"/> Yes | <input type="radio"/> No |
| Recreation drugs? | <input type="radio"/> Yes | <input type="radio"/> No |
| Energy levels low? | <input type="radio"/> Yes | <input type="radio"/> No |

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16. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	-----○-----	-----○-----	-----○-----	-----○-----
Rising out of chair	-----○-----	-----○-----	-----○-----	-----○-----
Standing	-----○-----	-----○-----	-----○-----	-----○-----
Walking	-----○-----	-----○-----	-----○-----	-----○-----
Lying down	-----○-----	-----○-----	-----○-----	-----○-----
Bending over	-----○-----	-----○-----	-----○-----	-----○-----
Climbing stairs	-----○-----	-----○-----	-----○-----	-----○-----
Using a computer	-----○-----	-----○-----	-----○-----	-----○-----
Getting in/out of car	-----○-----	-----○-----	-----○-----	-----○-----
Driving car	-----○-----	-----○-----	-----○-----	-----○-----
Looking over shoulder	-----○-----	-----○-----	-----○-----	-----○-----
Caring for family	-----○-----	-----○-----	-----○-----	-----○-----
Household chores	-----○-----	-----○-----	-----○-----	-----○-----
Lifting object	-----○-----	-----○-----	-----○-----	-----○-----
Reaching overhead	-----○-----	-----○-----	-----○-----	-----○-----
Showering or bathing	-----○-----	-----○-----	-----○-----	-----○-----
Dressing myself	-----○-----	-----○-----	-----○-----	-----○-----
Love life	-----○-----	-----○-----	-----○-----	-----○-----
Getting to sleep	-----○-----	-----○-----	-----○-----	-----○-----
Staying asleep	-----○-----	-----○-----	-----○-----	-----○-----
Concentrating	-----○-----	-----○-----	-----○-----	-----○-----
Exercising	-----○-----	-----○-----	-----○-----	-----○-----

17. Is there anything else Dr. Ritza should know about your current condition, your progress, or ways your current condition is affecting your life?

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature

Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific 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 adjustments 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.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be 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 acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Name

Patient Signature (Legal Guardian)

Witness Name

Witness Signature