

Personal History

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____
Birthdate: _____ Age: _____ Sex: M F
Email: _____
Business/Employer _____ Business Phone: _____
Type of Work: _____
Circle One: Married Single Widowed Divorced Separated Other Name: _____
Children(names and ages): _____
Emergency Contact: _____ Phone Number: _____ Relationship: _____
Who may we thank for referring you to this office? _____
Extended health benefits Self Spouse Parent School

Current Health Condition

Primary Complaint (PLEASE LIST ** ONLY ONE ****):** _____

Other doctors seen for this condition? Yes No Who? _____

Type of Treatment: _____ Results: _____

When did this condition begin? _____ Has the condition occurred before? Yes No

Is the condition: Job-related Auto-related Home Injury Fall Other: _____

Date of Accident: _____ Time of Accident: _____

What aggravates your condition? Sitting Standing Bending Lifting Walking
 Lying Down Cold Dampness Other: _____

What relieves your condition? Bed Rest Ice Heat Massage Medication
 Other: _____

Is it getting: Worse Constant Comes/Goes Better

Character of Pain: Sharp Dull Ache Pins & Needles Numb Burning
 Constant Comes and Goes

Place an X on the grade to indicate the severity of your pain:

LEAST 1 2 3 4 5 6 7 8 9 10 WORST

Does this problem interfere with: Work ___ Social time ___ Family ___ Hobbies ___ Sports ___

If you don't get the problem corrected, do you think it will get worse over the next 5 years? Yes No

Drugs you take now Anti depressants Painkillers/Muscle Relaxers Blood Pressure Medicine
 Insulin Cholesterol Other: _____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____

Have you had X-rays, MRI or CT scan taken in the last six months? No Yes If yes, where? _____

At its worst, how old does this problem make you feel? _____

Why Chiropractic?

People go to chiropractors for a variety of reasons and there are different levels of care. Please check the type of care desired so the Dr. Cranton may be guided by your wishes whenever possible. **Please circle one:**

Stage 1 Pain relief: Just get rid of the pain. Relief is short-term.

Stage 2 Rehabilitation: Get rid of the pain, but then fix this problem so that it doesn't come back!

Stage 3 Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan which includes diet, exercise and chiropractic so that I stay as healthy as possible.

History of Spinal Trauma

Have you ever been involved in **any motor vehicle accident** (car/snowmobile/atv/etc.) **minor or major?** Yes No

1.Date(year):_____ Injuries/Treatment: _____

2.Date(year):_____ Injuries/Treatment: _____

3.Date(year):_____ Injuries/Treatment: _____

Have you ever had any **major falls?** Yes No **Down the stairs On ice Off bikes From trees**

Other Describe: _____

Have you ever had any **sports injuries?** Yes No **Sprain/Strain Fracture Concussion Dislocation**

Other Describe: _____

Have you ever had any **surgery / operation?** Yes No **Appendectomy Tonsillectomy Gall Bladder**

Hernia Back surgery C Section Other: _____

Hospitalization (other than above): _____

Previous Chiropractic Care: No Yes Doctor's Name: _____

Approximate Date of Last Visit: _____

Family Health History

Name of Family Medical Doctor: _____ Specialist: _____

Please indicate any health issues that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? No Yes Whom? _____

Have your children ever had a spinal check-up? No Yes If yes, where and when? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Please CIRCLE any of the following you have had in the past six months:

Nervous System

- Nervous / Anxiety
- Numbness
- Paralysis
- Dizziness / Fainting
- Forgetfulness
- Confusion / Depression
- Convulsions
- Cold / Tingling Extremities
- Stress

Musculo-Skeletal

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing / Clicking Jaw
- General Stiffness

Genito-Urinary

- Bladder Trouble / Infections
- Painful / Excessive Urination
- Discolored Urine
- Bed wetting / Incontinence

General

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches / Migraines

C-V-R

- Chest Pain / S.O.B.
- Cholesterol Problems
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems / Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches / Infections
- Hearing Difficulty
- Stuffed Nose / Sinuses

Gastro-Intestinal

- Poor / Excessive Appetite
- Excessive Thirst
- Frequent Nausea / Vomiting
- Heartburn
- Diarrhea / Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas / Bloating After Meals
- Heartburn
- Crohn's Disease
- Colitis / IBS / Celiac Disease

Female

- Period Irregularity / Menopause
- Bad cramps / heavy bleeding
- Vaginal Pain / Infections
- Breast Pain / Lumps
- PMS / Moods

Male

- Prostate / Sexual Dysfunction

Females Only

When was your last period?

Are you pregnant?
 Yes No Not Sure

Intake

- Coffee – How many? _____
- Tea
- Alcohol
- Cigarettes
- White Sugar

Satisfaction with Diet

- Highly Satisfied
- Dissatisfied
- Highly Dissatisfied

Do you have a regular exercise program?

- Yes – Type and frequency

- No

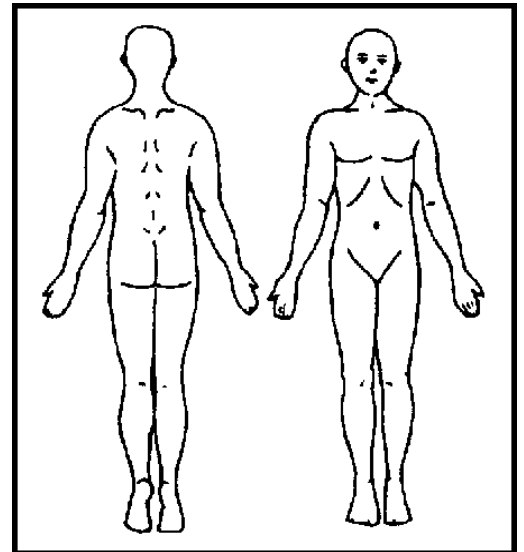
Lifestyle Stress Levels

- High
- Moderate
- Very Little

Check any of the following diseases you have / had:

- Pneumonia
- Mumps
- Influenza
- Rheumatic Fever
- Small Pox
- Pleurisy
- Polio
- Chicken Pox
- Arthritis
- Tuberculosis
- Diabetes
- Epilepsy
- Whooping Cough
- Cancer
- Mental Disorder
- Anemia
- Heart Disease
- Lumbago
- Measles
- Thyroid
- Eczema
- Chronic Fatigue Syndrome
- Fibromyalgia
- Epstein Barr Virus Syndrome
- Gillian Barre Syndrome

Please outline on the diagram the area of your discomfort and any radiation of pain.



Please check if any of the following pertain to you:

- Cancer in last 5 years
- Currently Pregnant
- Photosensitive Medications
- Tattoos
- Acute Infection of the Site

Please Read Carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic/naturopathic laser therapy assessment and treatment, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by Dr Cranton and / or anyone working in this clinic authorized by Dr Cranton.

I have had an opportunity to discuss with Dr Cranton / staff member and / or with other office or clinic personnel, the nature and purpose of any treatment and procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic/naturopathic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, rib fractures, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

EXTENDED HEALTH BENEFITS

CHECK-OFF LIST

Name _____ Date _____

We have prepared this list for you to help you get ALL the information you need when you call for your work Extended Health Benefits. We have included questions for all of the services we offer in our office. Dr. Cranton is licensed as both a Chiropractor and a Naturopathic Doctor, performs acupuncture, and is certified to cast and order custom orthotics.

Do you have Extended Health Benefits through your work or school? Yes No
Does your spouse, mother or father have Extended Health Benefits though his/her work?
 Yes No (you are done with this form)

INFORMATION TO RECORD BEFORE YOU CALL:

Your work Insurance Company - Name: _____ Phone #: _____
Employer: _____ Employee: _____
Employee ID#: _____ Group policy #: _____

INFORMATION TO GET WHEN YOU CALL:

Is there a deductible? Yes - How much? \$ _____ No
Is this a family plan? Yes No
Is your limit: per calendar year per fiscal year _____ to _____ per 12 consecutive months

DO YOU HAVE CHIROPRACTIC COVERAGE? Yes No

What is your limit per year? \$ _____
What is your limit per visit? \$ _____
Do you have x-ray coverage? Yes No - Is it included in your maximum? Yes No

DO YOU HAVE NATUROPATHIC COVERAGE? Yes No

What is your limit per year? \$ _____
Is there a maximum per visit? \$ _____
Are there a maximum number of visits? No Yes _____
Are supplements covered if prescribed by a Naturopath? No Yes - maximum \$ _____

DO YOU HAVE ACUPUNCTURE COVERAGE? Yes No

What is your limit per year? \$ _____
What is your limit per visit? \$ _____
Are there a maximum number of visits? No Yes _____

DO YOU HAVE PRIVATE LAB COVERAGE? Yes No

Are private labs covered? (E.g. hair analysis, blood or urine or allergy tests) No Yes - maximum \$ _____

OTHER ITEMS TO CHECK ON:

Do they cover orthopedic cervical pillows? Yes No
Do you have coverage for COMPRESSION HOSIERY OR STOCKINGS? Yes No
What is your limit per year? \$ _____

Do you have CUSTOM ORTHOTICS coverage?
What is your limit per year \$ _____
How many pairs can you order? _____
Do you need a referral Chiropractor M.D. No
Do you get one pair per year or every second year?