MANDZAK CHIROPRACTIC HEALTH CENTRE
101 Mary Street West , Suite 101
Whitby, Ontario L1N 2R4
Telephone: 905-666-2934

Please Complete:

Name :_____E-Mail_____

Address:_____

City: _____ Postal Code: _____

Telephone: (h) _____ (w) _____

Date of Birth: (y/m/d) _____ Age: _____ Sex: F ____ M _____

Marital Status : Single _____ Married _____ Divorced _____ Other _____

Occupation: _____Full Time: _____ Part Time: _____

How Did You Hear About The Clinic? _____
(If by a friend or patient, please give persons name)

Extended Benefits: Yes ☐ No ☐ Policy # _____

Physicians Name: _____

Phone Number: _____

Address: _____

City: _____ Postal Code: _____

Was The Injury The Result Of A Motor Vehicle Accident? Yes _____ No _____

If So, Date Of Accident: _____

Is This A Reported Work Related Injury (WSIB)? Yes _____ No _____

Employer Name: _____ Telephone: _____

Address: _____

City: _____ Postal Code: _____

S.I.N.#: _____

I, _____ herby consent that the above information is correct.

Patient Signature: _____ Date: _____

Witnessed: _____

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

PRECONSULTATION GENERAL QUESTIONNAIRE

NAME:_____ DATE: _____

What is your main reason for consulting our office (in other words, what are your health goals?)

(Check one)

1. I have no special problems: I understand the role of chiropractic health care (___)
2. I have a disease or symptom and I am interested in help with this specific problem: in addition, I am interested in learning about my health potential and the role of chiropractic in improving my family's health. (___)
3. I have a disease or symptom and I am interested in help with this problem and in learning how to prevent it in the future. (___)
4. I have a disease or symptom and I am interested in help with the specific problem (___)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. What is your major complaint?_____
2. How long have you had this complaint?_____
3. How long has it been since you really felt good?_____
4. What do you believe is wrong with you?_____

PLEASE CHECK FOR EACH OF THE FOLLOWING:

	YES	NO
1. Are your symptoms worse at night?	(___)	(___)
2. Are you often troubled by headaches?	(___)	(___)
3. Has your weight changed more than 10 pounds in the last year?	(___)	(___)
4. Have you noticed blood or mucus in your bowel movements?	(___)	(___)
5. Are you troubled by pain or tightness in your chest exertion?	(___)	(___)
6. Are you troubled by frequent or persistent cough?	(___)	(___)
7. Are you subject to faints, dizzy spells or blackouts?	(___)	(___)
8. Have you any lumps or unusual swelling anywhere on your body?	(___)	(___)
9. Have you noticed that you get dizzy when you look upwards?	(___)	(___)

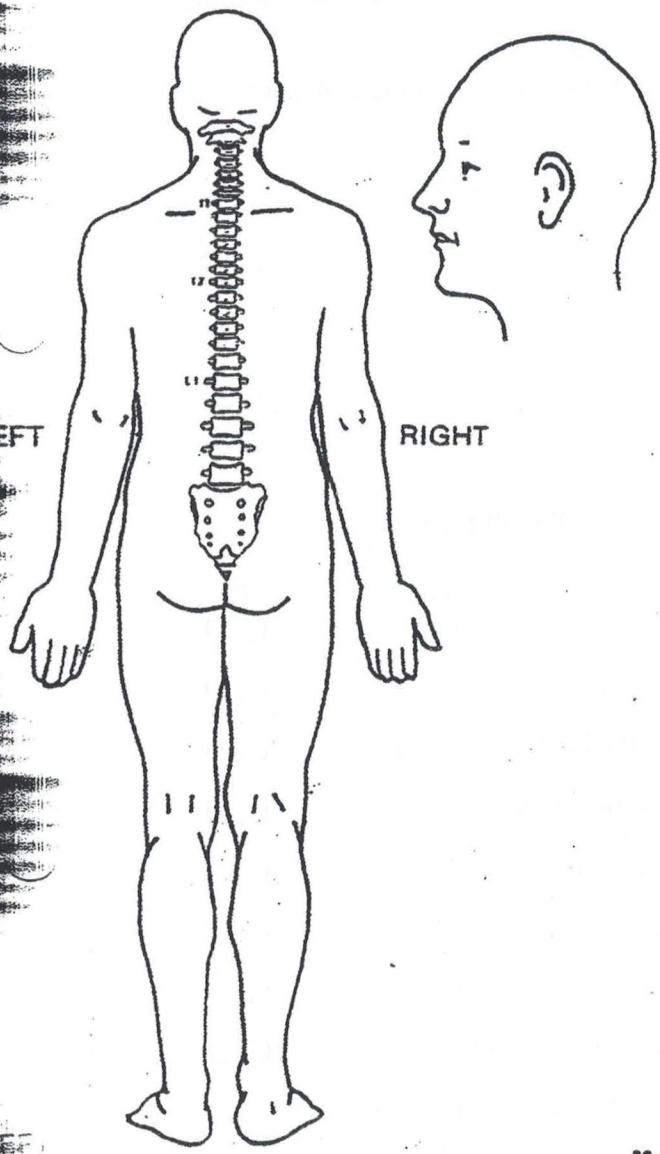
PLEASE COMPLETE OTHER SIDE OF PAGE

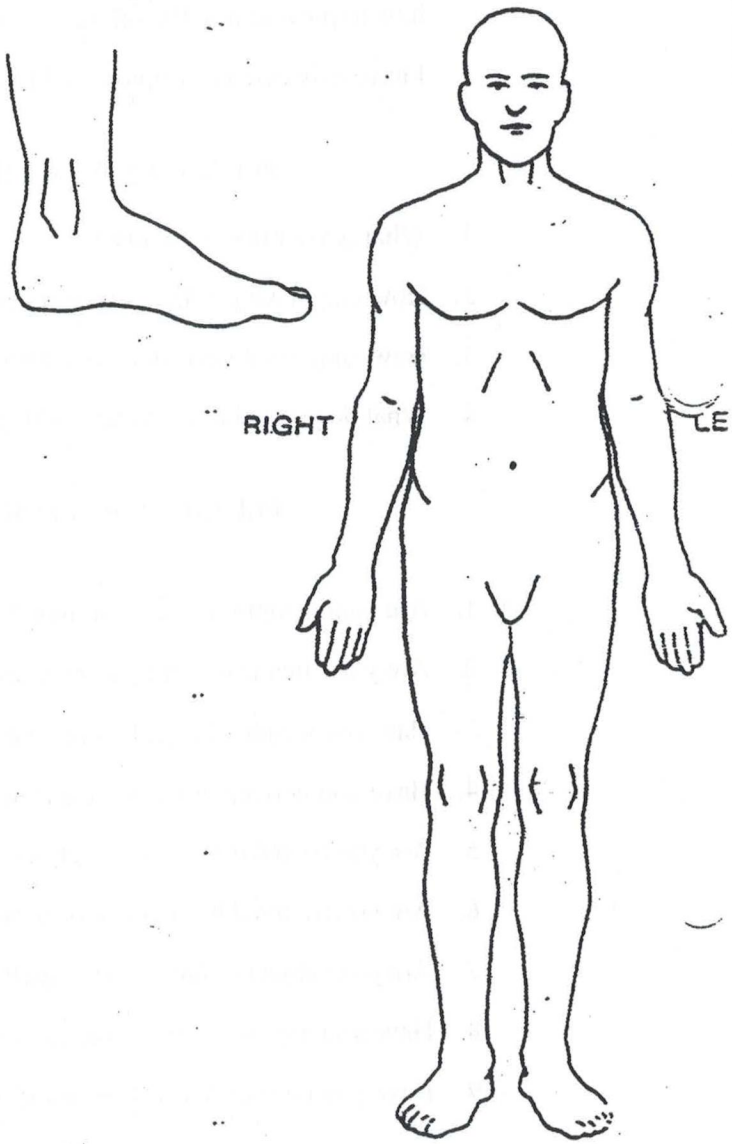
Dr. Tim Mandzak D.C.
Doctor of Chiropractic

PAIN DIAGRAM

Please indicate in the diagrams below , any areas in which you feel pain , burning , tingling or numbness . You may add any other information that you feel would be helpful .

PAIN - XXXX BURNING - 00000 TINGLING - • • • • NUMBNESS - ////////





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LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

Patient Name:_____ File #:_____ Date:_____

PLEASE READ INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section may relate to you, but just mark the box which most closely describes your problem.

Rate the severity of your back pain by circling a number on the following scale:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Excrutiating Pain

SECTION 1 – PAIN INTENSITY
- ☐ The pain comes and goes and is very mild
- ☐ The pain is very mild and does not vary much
- ☐ The pain comes and goes and is moderate
- ☐ The pain comes and goes and is severe
- ☐ The pain is severe and does not vary much

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)
- ☐ I would not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it causes pain
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it
- ☐ Because of the pain, I am unable to do some washing and dressing without help
- ☐ Because of the pain I am unable to do any washing and dressing without help

SECTION 3 – LIFTING
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights, but it causes extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very heavy weights
- ☐ I cannot lift or carry anything at all

SECTION 4 – WALKING
- ☐ I have no pain walking
- ☐ I have some pain on walking but it does not increase with distance
- ☐ I cannot walk more than one km without increasing pain
- ☐ I cannot walk more than ½ km without increasing pain
- ☐ I cannot walk more than ¼ km without increasing pain
- ☐ I cannot walk at all without increasing pain

SECTION 5 – SITTING
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than half an hour
- ☐ Pain prevents me from sitting for more than 10 minutes
- ☐ I avoid sitting because it increases pain straight away

SECTION 6 – STANDING
- ☐ I can stand as long as I want without pain
- ☐ I have some pain on standing but it does not increase with time
- ☐ I cannot stand for longer than one hour without increasing pain
- ☐ I cannot stand for longer than ½ hour without increasing pain
- ☐ I cannot stand for longer than 10 minutes without increasing pain
- ☐ I avoid standing because it increases the pain straight away

SECTION 7 – SLEEPING
- ☐ I get no pain in bed
- ☐ I get pain in bed but it does not prevent me from sleeping well
- ☐ Because of pain my normal night's sleep is reduced by less than 1/4
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4
- ☐ Pain prevents me from sleeping at all

SECTION 8 – SOCIAL LIFE
- ☐ My social life is normal and it gives me no pain
- ☐ My social life is normal but increases the degrees of pain
- ☐ Pain has no significant pain effect on my social life apart from limiting my more energetic interests (i.e. dancing)
- ☐ Pain has restricted my social life and I do not go out very often
- ☐ Pain restricted my social life to home
- ☐ I have hardly any social life because of pain

SECTION 9 – TRAVELLING
- ☐ I get no pain whilst travelling
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse
- ☐ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel
- ☐ I get extra pain whilst travelling which compels me to seek alternative forms of travel
- ☐ Pain restricts all forms of travel
- ☐ Pain prevents all forms of travel except that done lying down

SECTION 10 – CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates but overall is definitely getting better
- ☐ My pain seems to be getting better but improvement is slow at present
- ☐ My pain is neither getting better nor worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

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NECK PAIN AND DISABILITY INDEX (Vernon-Mior)

Patient Name:_____ File #:_____ Date:_____

PLEASE READ INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section may relate to you, but just mark the box which most closely describes your problem.

Rate the severity of your neck pain by circling a number on the following scale:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Excrutiating Pain

SECTION 1 – PAIN INTENSITY
- ☐ I have no pain at this moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is the worst imaginable at the moment

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help everyday in most aspects of my self care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

SECTION 3 – LIFTING
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights, but it causes extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very heavy weights
- ☐ I cannot lift or carry anything at all

SECTION 4 – READING
- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck
- ☐ I can't read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

SECTION 5 – HEADACHES
- ☐ I have no headaches at all
- ☐ I have slight headaches which come infrequently
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently
- ☐ I have severe headaches all the time

SECTION 6 – CONCENTRATION
- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

SECTION 7 – WORK
- ☐ I can do as much work as I want to with no difficulty
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't do any work at all

SECTION 8 – DRIVING
- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I can't drive my car as long as I want because of moderate neck pain
- ☐ I can hardly drive my car at all because of severe pain in my neck
- ☐ I can't drive my car at all

SECTION 9 – SLEEPING
- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed (2 -3 hours sleepless)
- ☐ My sleep is greatly disturbed (3 -5 hours sleepless)
- ☐ My sleep is completely disturbed (5 – 7 hours sleepless)

SECTION 10 – RECREATION
- ☐ I am able to engage in all my recreation activities with no neck pain at all
- ☐ I am able to engage in all my recreation activities with some pain in my neck
- ☐ I am able to engage in most but not all of my usual recreation activities because of pain in my neck
- ☐ I am able to engage in few of my usual recreation activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all

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