



Maple Ridge  
**Chiropractic**  
& Massage  
New Patient Intake Form

**Patient Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Gender:  Male  Female    Marital Status:  Single  Married  Divorced  Widowed  
How did you hear about our office? \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Employment Information**

Current Employment:  Employed  Unemployed  Homemaker  Student  Other  
Employer's Company Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

**Here for:**  Alignment  Posture  Athletic Performance  Pain Relief

**Presenting problem**

What is the presenting problem/chief complaint? \_\_\_\_\_  
When/how did this start? \_\_\_\_\_  
Have you had this or similar conditions in the past?  Yes  No  
Is this condition getting (circle): Worse Better Same Recurring  
Is this pain (circle): Dull Achy Sharp Electrical Throbbing Stiffness Cramps  
Rate pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)  
Frequency: (Percentage of day symptoms felt) 0%-25% 26%-50% 51%-75% 76%-100%  
Any (circle): Numbness / Tingling / Weakness / Changes in Bowel or Bladder habits/ Head Ache /  
Nausea / Pain with Sneezing, Coughing, Straining / Dizziness / Fever / Fatigue  
How does this condition interfere with your daily routine? \_\_\_\_\_  
What aggravates your condition? \_\_\_\_\_  
What relieves your condition? \_\_\_\_\_  
Types of previous treatment and/or surgery for this condition? \_\_\_\_\_

**Personal Health History**

Overall Stress Level 0 1 2 3 4 5 6 7 8 9 10  
Overall Health Level 0 1 2 3 4 5 6 7 8 9 10  
Medications, including over the counter, you currently take: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Vitamins/Supplements you currently take: \_\_\_\_\_  
List any serious illness you have had: \_\_\_\_\_  
Date of last physical examination: \_\_\_\_\_ Please list any abnormal findings: \_\_\_\_\_  
Surgeries: \_\_\_\_\_  
Have you ever been diagnosed with cancer?  Yes  No If yes, what kind? \_\_\_\_\_  
Family health history: describe any conditions/diseases (i.e. heart disease, diabetes, other inherited diseases) suffered by family members: \_\_\_\_\_

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

## Informed Consent

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. It is important that you also understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

### Consent of Professional Services and Release of Information

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care, massage therapy or any clinic services that he/she deems necessary in my case; and further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, insurance companies, workers compensation carriers, welfare funds or the patients' employer. I authorize Maple Ridge Chiropractic & Massage to contact me through mail, fax, phone, voicemail, and/or text regarding my care.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_