WELCOME

TO OUR OFFICE

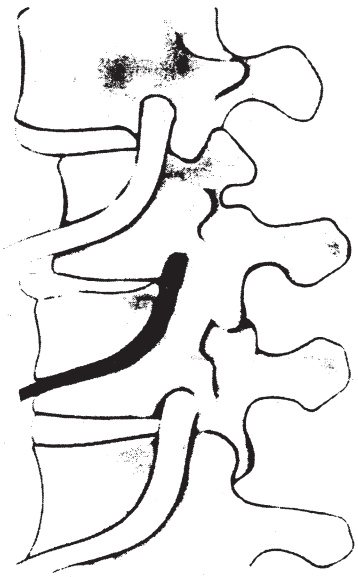
MISSION STATEMENT

To support everyone in their quest for health and well-being by aligning the spine in order to allow Innate(LIFE) to flow freely from above, down, inside and out to maximize healing potential, restoring bodily function allowing you to awaken to your spiritual vision and ultimately live it.

Our purpose is to adjust and educate everyone because Chiropractic works and everyone deserves to be adjusted.

Dr.R.J.Folkard,D.C.

SUBLUXATION



DEFINITION: A spinal bone (vertebra) that is out of place and blocking the nerve.

ALL body functions are controlled by the BRAIN sending and receiving mental impulses (LIFE) over the NERVOUS SYSTEM. When spinal bones (vertebrae) are SUBLUXATED (misaligned), nerve supply is blocked, creating DIS-EASE, then SYMPTOMS.

Our goal is to locate the SUBLUXATIONS that are CAUSING your health problems.

1) Realize the human body is a self-regulating and self-healing organism.

2) Dis-ease is the result of imbalance and disharmony in an otherwise perfect organism. Imbalance is an outside-in mechanism originating with the following types of stressors:
   (a) chemical (toxic)
   (b) mental/emotional
   (c) traumatic (physical accidents, injuries, etc.)

3) Dis-ease also comes from an interference of the life force that runs the human body. This life force (electrical energy), conducted by the nervous system, is disrupted by spinal subluxation.

4) Chiropractors are the only professionals trained to detect and correct spinal subluxation.

5) Health is achieved through the pursuit of balanced efforts directed toward harmony with the intelligence that runs the body.

6) We are never victims, but rather creators of either poor health or good health.

7) Balance must exist in body, mind and spirit if we are to achieve our own unique purpose on this earth.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I clearly understand and agree that all services rendered by 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, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Confidential Patient Health Record

DATE	FILE NO.
HEALTH CARD #	

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Birth Date: ___/___/___ (D M Y) Age: ____ Sex: ☐ M ☐ F

Business/Employer: _____ Type of Work: _____

Business Phone: _____ Circle One: Married Single Widowed Divorced Separated No. of Children: ____

Name of Spouse: _____

Name of Emergency Contact: _____ Phone: _____ Relationship: _____

Referred to this office by: _____

REASON FOR CONSULTING THIS OFFICE

☐ I am here today for a Spinal Check-up. ☐ I have a specific health problem and require help with this problem.

What is your MAJOR complaint? _____

How LONG have you had this condition? _____

Have you had this or a SIMILAR CONDITION in the PAST? _____

Is this Condition(?) ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other _____

Is this Condition(?) ☐ Getting Worse ☐ Constant ☐ Comes and Goes

Have you seen another Doctor for this condition? ☐ Yes ☐ No Who? _____

Type of Treatment? _____ Results? _____

Family Physician - Name and Address: _____

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Birth Control Pills ☐ Asthma Inhalers ☐ Aspirin
☐ Vitamins ☐ Other _____

Do you suffer from any conditions other than that for which you are now consulting us? _____

PAST HEALTH HISTORY

Please check and describe:

Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia
☐ Back Surgery ☐ Hysterectomy ☐ Cancer Surgery ☐ Broken Bones
☐ Radiation Treatment/Chemotherapy ☐ Other _____

Have you been in a car accident? ☐ Never ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years

Describe: _____

Have you had any other injury, fall or accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years

Describe: _____

Hospitalization (other than above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name _____

Approximate date of last visit: _____ Were X-rays taken? _____

Below are 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.

1) CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ HIV-AIDS
- ☐ Eczema

INTAKE (per day)

- ☐ Coffee _____
- ☐ Tea _____
- ☐ Alcohol _____
- ☐ Cigarettes _____
- ☐ White Sugar _____

2) CHECK IN BOX ANY CURRENT SYMPTOMS, UNDERLINE ANY SYMPTOMS YOU HAVE HAD IN THE PAST.

MUSCULO-SKELETAL

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

NERVOUS SYSTEM

- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discoloured Urine

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

When was your last period? _____

Are you pregnant? ☐ Yes ☐ No ☐ Not sure

3) FAMILY HISTORY

The following members have the same or similar problems as I do:

CONDITION			
Arthritis	☐ Spouse	☐ Children	☐ Brother/Sister
Asthma-Hay Fever	☐ Spouse	☐ Children	☐ Brother/Sister
Back Trouble	☐ Spouse	☐ Children	☐ Brother/Sister
Cancer	☐ Spouse	☐ Children	☐ Brother/Sister
Diabetes	☐ Spouse	☐ Children	☐ Brother/Sister
Disc Problems	☐ Spouse	☐ Children	☐ Brother/Sister
Emotional Problems	☐ Spouse	☐ Children	☐ Brother/Sister
Headaches & Migraines	☐ Spouse	☐ Children	☐ Brother/Sister
High Blood Pressure	☐ Spouse	☐ Children	☐ Brother/Sister
Kidney Trouble	☐ Spouse	☐ Children	☐ Brother/Sister
Nervousness	☐ Spouse	☐ Children	☐ Brother/Sister
Pinched Nerves	☐ Spouse	☐ Children	☐ Brother/Sister
Sinus Trouble	☐ Spouse	☐ Children	☐ Brother/Sister
Stomach Trouble	☐ Spouse	☐ Children	☐ Brother/Sister
Other	☐ Spouse	☐ Children	☐ Brother/Sister