DR. SILVIA VILLANI, DC
WOODBRIDGE AVENUE CHIROPRACTIC AND WELLNESS CENTRE
53 WOODBRIDGE AVENUE, UNIT 4
WOODBRIDGE, ON, L4L 9K9
P: 905-264-8107 F: 905-264-8542

PATIENT INFORMATION **DATE:**

FIRST NAME	LAST NAME			GENDER □ M □ F
ADDRESS	APT	CITY	PROV	POSTAL CODE
HOME PHONE	CELL PHONE	DATE OF BIRTH (DD/MM/YYYY)		
EMAIL ADDRESS		OCCUPATION		
MARITAL STATUS: □ Married □ Single □ Divorced □ Other				
EMERGENCY CONTACT: Name	Telephone	Relationship		
FAMILY DOCTOR: Name		Telephone		
HOW DID YOU HEAR ABOUT US?				

HEALTH INFORMATION

Please list your medical conditions: Medications: Allergies: _____.

Alcohol: □Yes □ No
Smoking: □Yes □ No
Regular exercise: □Yes □No
Hours of sleep /night: _____.
Are you pregnant? □Yes □No
Due date: _____.

Previous surgeries and year:

Accidents/Injuries/Fractures:

- TYPE YEAR AREA OF INJURY .
- TYPE YEAR AREA OF INJURY .
- TYPE YEAR AREA OF INJURY .

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS OR ANY OF THE FOLLOWING SYMPTOMS REGULARLY

□ loss of consciousness □ dizziness □ numbness/tingling □ weakness □ frequent headaches
□ vision change □ choking/trouble swallowing □seizures □ history of stroke □ hearing loss

□ shortness of breath □asthma □bronchitis □ emphysema

□ chest pain □atherosclerosis/vascular disease □history of heart attack □ aneurysm
□ diabetes □high blood pressure □high cholesterol

□ loss of bowel/bladder function (□stool □urine) □prostate problems □kidney stones
□ difficulty with urination (difficulty starting stream, burning, blood in urine)

□ abdominal pain □vomiting/diarrhea □gastric/duodenal ulcer □pancreas problems □ liver disease

□ osteoarthritis □rheumatoid arthritis □scoliosis □ ankylosing spondylitis □osteoporosis

□ recurrent fevers □ drenching night sweats □ weight loss

□ history of cancer - type:

□ skin conditions:

□ infections: □HIV □ tuberculosis □ herpes □ hepatitis

□ internal objects/devices: □ pacemaker □ metal/pins □ artificial joints □*Where?*

Women: □painful periods □excessive flow □cramping □hot flashes

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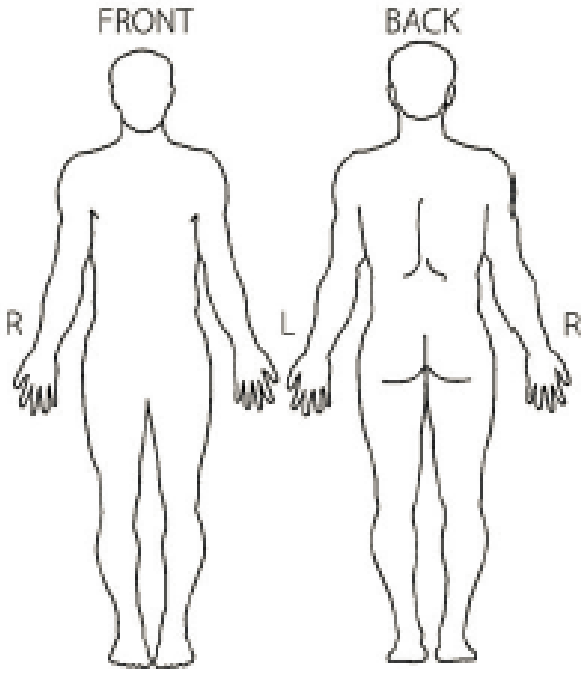
PLEASE CHECK IF THERE IS A FAMILY HISTORY OF THE FOLLOWING CONDITIONS AND SPECIFY FAMILY MEMBER	
□ osteoarthritis	□ rheumatoid arthritis
□ heart attack	□ cancer
□ stroke	□ diabetes
□ other	

CHIROPRACTIC INFORMATION
What is the reason for seeking care today:
Is this related to: □ Recent motor vehicle accident □ Work-related injury/accident (WSIB)
Have you had an xray for this problem? □Yes □ No When?
Have you seen a chiropractor before for this condition? □Yes □No

PLEASE MARK ALL THE AREAS OF THE BODY WHICH YOU FEEL ARE PAINFUL OR PROBLEMATIC USING THE LETTER KEY BELOW:



P – Pins and Needles

N - Numbness

B – Burning

D – Dull Ache

S - Sharp/Stabbing

T – Tight/Stiff

PATIENT'S DECLARATION

All of the above health information is complete and correct to the best of my knowledge. I understand that omitting health information may be dangerous to my health.

Signature _____ Date_____.

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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

Dr. Silvia Villani, DC
Woodbridge Avenue Chiropractic & Wellness Centre
53 Woodbridge Avenue, Unit 4
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INFORMED CONSENT FOR ACUPUNCTURE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits

Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks

The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy

The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives

Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

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 read this form and 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 acupuncture treatment as proposed to me.

_____	_____	_____
Name (Please Print)	Signature of Patient (or legal guardian)	Date
_____		_____
Signature of Chiropractor		Date

Adapted from: CCPA