Infinite Health Dr. George Traitses 2914 Sheppard Ave. E., # 206 Scarborough, Ont. M1T 3J4, (416) 499 5656

PERSONAL HISTORY

08.03.06

Today's Date:_____

Name:_____

Address_____

Apt. #_____ City:_____ Province_____

Postal Code_____ Home Phone:_____

Business Phone:_____Ext_____ Birth Date:_____ Age:_____

Fax:_____ E-Mail_____

Sex: M F Height:_____ Weight:_____ Occupation:_____

Business/Employer:_____ Address:_____

Circle One: Single Married Widowed Divorced Separated In Limbo

Soc.Ins.#_____ No. of Children_____

In Emergency Contact_____Phone_____

Referred To This Office By:_____

Chiropractic is not covered by OHIP, but is covered by many of the major insurance companies. Please check your and your spouse's company policies for coverage.
We will issue monthly receipts upon request. You are responsible for all additional fees.

Insurance Company Name_____ Phone #_____

Policy Number_____ Address_____

If this is a Motor Vehicle Accident please notify us immediately and please give us your

Lawyer's Name_____ Phone #_____

CURRENT HEALTH CONDITION

What have you heard about chiropractic?_____

Purpose of this Appointment:_____

Major Complaint: _____

Other Complaints:_____ How long have you had the complaint(s)?_____

Did you ever have an earlier problem that was the same or similar?_____

Did it appear: Slowly Immediately? Is it: Sharp Dull? Throbbing? Intermittent? Moving?

Is the problem in the: (circle all which are affected)

Head Face Neck Jaw Upper Back Shoulders Arms Elbows Forearms Wrists Hands Fingers Chest Ribs Abdomen Low Back Pelvis Groin Hips Tail Bone Thighs Knees Legs Ankles Feet Toes

Borg Pain Scale
Subjective Pain Level: On a scale of 1 to 10, place an X to indicate your current pain level.

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
( ) 0	( ) 1	( ) 4	( ) 7	( ) 10
	( ) 2	( ) 5	( ) 8	
	( ) 3	( ) 6	( ) 9	

Other doctors seen for this condition:_____Type of Treatment _____

Results_____When did this condition begin: _____

Has this condition occurred before? Yes No Others in your family with this same problem or a similar one?

If yes who? _____ How often does it bother you now?_____

When is it at its worse, how does it feel? _____

When it is at its worse, how does it interfere with your normal daily activities?_____

If Yes, How? _____

Is The Condition :____Job Related ____Auto Related ____Home Injury Date of Accident/Injury_____

Time of Accident/Injury_____ Medication You Now Take: ____Nerve Pills ____Pain Killers

____Muscle Relaxants ____Blood Pressure ____Insulin ___Aspirin/Similar ____Birth Control Pill

____Diuretic (water) Other_____ Do You Wear A Shoe Lift? Yes No

Do you suffer from any condition other than that which you are now consulting us?

_____

Ransford Pain Drawing

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation. Include all affected areas.
Numbness
- - - - - - -
- - - - - - -

Pins & Needles
OOOOOO
OOOOOO

Burning
xxxxxx
xxxxxx

Aching
******
******
Stabbing
//////
//////

PAST HEALTH HISTORY

Please Circle or Describe:

Major Surgery/Operations: Appendix Tonsils Gall Bladder Stomach Bowel Cysts Hernia Heart Back

Neck Leg Tubes Tied Hysterectomy Other_____

Major Accidents or Falls: _____ Hospitalization (other than above):_____

Have you had X-Rays taken. If so where?_____ Previous Chiropractic Care: Y N

If yes Doctor's name and approximate date of last visit: _____

Have you been treated for any health condition in the last year? Yes No If Yes, Please explain:

_____

Your MD.'s name, address, Phone #_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:

b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibly of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There is rare reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spam, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment os substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same treatments.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____2005

_____ _____ _____

Patient Signature (Legal Guardian) Witness of Signature

Name _____ Name:_____

(Please print) (Please print)