

ROF	MON	TUES	WED	THURS	FRI
GUEST					

- Dr. Justine Blainey-Broker, B.Sc., D.C.
- Dr. Blake Broker, B.Sc, D.C.
- Dr. Steve Gillis, BPE, ART, D.C.
- Dr. Dave Lee, B.Sc., D.C.
- Other

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SUB		
X-RAY C/SP		
X-RAY T/SP		
X-RAY L/SP		
X-RAY OTHER		
GAIT		
TOTAL		



220 Wexford Road, Unit 2 Brampton, ON L6Z 4N7 (905) 840-WELL

Confidential Patient Case History Form

Name:	Age:	Today's Date:	
Address:	City:	Province/State:	Postal Code:
Home Telephone Number:	Cellphone Number:		
Work Telephone Number:	Occupation	Employed by:	
Email:	Birthday (MM/DD/YY):	Gender:	
Relationship: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>		Partners Name:	
Number of children:		Names of children:	
Have you had previous Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Chiropractors Name:	
Medical Doctors Name:		Medical Doctor Phone #:	
Reason for consulting our office:			

Your Health Profile

Why This Form Is Important

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

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	Yes	No	Unsure		Yes	No	Unsure
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas? (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?			
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular Chiropractic care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you involved in any car accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you fallen/jumped from a height over three feet? ie (crib, bunkbed, tree)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Adult Years (Age 18 to present)

	Yes	No		Yes	No
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1-10 describe your stress level (1 = None 10 = Extreme)		
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Occupational:Choose an item. Personal:Choose an item.		

On a scale of 1-10, rate yourself on the following with 1 being poor and 10 being excellent:

Diet: Exercise: Sleep: Mental Clarity/Focus: General Health:

Wellness Checkup: Yes No Specific Concerns? _____

If you are experiencing pain, is it:

Sharp: Dull: Numbness: Tingling: Aching: Burning: Stabbing: Radiating:

Since the problem started, it is: About the Same Getting Better Getting Worse

What makes it worse? _____

How frequent is the complaint? Constant Daily Intermittent Night Only

How long does it last? All day A Few Hours Minutes

Is there anything you can do to relieve the problem? Yes No If yes, describe: _____

It Interferes with: Work Sleep Walking Sitting Hobbies Leisure

On a scale of 1 – 10 what is your problem level [Click](#)

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Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem

- | | | | | | | | |
|------------------------|--------------------------|------------------------|--------------------------|------------------------|--------------------------|-----------------|--------------------------|
| Headaches | <input type="checkbox"/> | Pins & Needles in Legs | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | Neck Pain | <input type="checkbox"/> |
| Pins & Needles in Arms | <input type="checkbox"/> | Loss of Smell | <input type="checkbox"/> | Back Pain | <input type="checkbox"/> | Loss of Balance | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | Buzzing in Ears | <input type="checkbox"/> | Ringing in Ears | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> |
| Numbness in Fingers | <input type="checkbox"/> | Numbness in Toes | <input type="checkbox"/> | Loss of Taste | <input type="checkbox"/> | Upset Stomach | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | Depression | <input type="checkbox"/> | Irritability | <input type="checkbox"/> | Tension | <input type="checkbox"/> |
| Sleeping Problems | <input type="checkbox"/> | Stiff Neck | <input type="checkbox"/> | Cold Hands | <input type="checkbox"/> | Cold Feet | <input type="checkbox"/> |
| Diarrhea | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | Fever | <input type="checkbox"/> | Hot Flashes | <input type="checkbox"/> |
| Cold Sweats | <input type="checkbox"/> | Sensitive Eyes | <input type="checkbox"/> | Problem Urinating | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> |
| Mood Swings | <input type="checkbox"/> | Menstrual Pain | <input type="checkbox"/> | Menstrual Irregularity | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |

Have you had any of the following major illnesses? Heart disease: Diabetes: Cancer:

Please list any other major illnesses you have suffered from: _____

Please list the doctor of any major surgeries you have had: _____

Please list any medication you are currently taking: _____

Stress Test

When in your life did you experience any of the stresses listed below: C (child), T (teenager), A (adult), N (not at all)

I: PHYSICAL STRESS

Birth Trauma	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Slips/Falls	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Sports Injuries	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Poor Posture	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Extensive Computer Work	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Carrying Heavy Objects	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Repetitive lifting/bending	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Continuous sitting/standing	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Bone Fracture/Surgery	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Driving for many hours	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Car accidents	How many? Enter	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Physical Abuse	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	
Work Injuries	How many? Enter	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Sleeping Position/Stomach	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:	

II: CHEMICAL STRESS:

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Smoker	Amount? Click	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Second Hand Smoke		C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Poor Diet		C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Caffeine	Amount? Click	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Excessive Sugar		C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Artificial Sweeteners		C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Prescription Drugs		C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Over The Counter Drugs (Tylenol, Advil, etc)		C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Environmental Pollution (Air, Water, Etc)		C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:

III: EMOTIONAL STRESS:

Relationships	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Careers	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Children	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Money	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Fast-Paced Life	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Internalized Feelings	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Perfectionist	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Procrastinator	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Sickness or Loss of a Loved One	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Quick Temper	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:
Verbal Abuse	C <input type="checkbox"/>	T <input type="checkbox"/>	A <input type="checkbox"/>	N <input type="checkbox"/>	Explain:

What do you feel is your primary stress? Physical Chemical Emotional

Explain: [Click or tap here to enter text.](#)

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

	Name(s)	Condition(s)
Children		
Sister(s)		
Spouse		
Mother		
Father		
Brother(s)		
Others:		

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Brampton: 220 Wexford Road Unit 2 Brampton, ON L6Z 4N7

Ph: (905) 840-9355 Fax: (905) 840-5433

www.drjustineblainey.com

www.blaineywellness.com

<p><u>CONSENT FOR:</u></p> <input type="checkbox"/> Examination <input type="checkbox"/> Adjustment
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CONSENT TO CHIROPRACTIC TREATMENT AND /OR EXAMINATION

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. Discuss forms of treatment with your doctor you are comfortable with.

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.

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- 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 in most severe cases only.

- 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

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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.

- Consent to all encompassing chiropractic treatments knowing the Doctor(s) will discuss ahead of time them with me. (Example: Orthotics, change of techniques etc.)
- Consent to seeing another JBWC Doctor if/when needed. (Example: Time restrictions, scheduling, acute condition needing help and my primary Doctor is away etc.)
- I understand that the Justine Blainey Wellness Centre has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information.
- I understand that I may receive the following: newsletters, Thank you cards, Birthday cards, phone calls, health packages etc. that may be of interest to me.
- I hereby authorize the release of my medical/chiropractic records or copies of the same to such parties that the doctor may deem necessary as it relates to my case, and do hereby hold harmless anyone from such actions. This only occurs when patient asks in cases of emergency or for safety.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the examination and/or assessment of my condition and/or 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 and/or examination(s) as proposed to me.

Patient Name (Please Print)

Signature of patient(or legal guardian) Date

Name of Chiropractor or Assistant

Signature of Chiropractor or Assistant Date