

Dr. Jabeen Jussa, B.Sc., D.C.  
DOCTOR OF CHIROPRACTIC

MAINTAIN. RESTORE. ENHANCE

Thank you for choosing our clinic for your Chiropractic Needs. Please complete this form. If you have any questions, please feel free to ask.

Date: \_\_\_\_\_

**PATIENT INFORMATION:**

NAME \_\_\_\_\_ DATE OF BIRTH (M/D/Y) \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

PHONE # Home \_\_\_\_\_ Mobile \_\_\_\_\_ Work \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

MEDICAL DOCTOR NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

CARE CARD # \_\_\_\_\_ RECEIVE EMAIL NEWSLETTERS? (approx 5/year) Y N

**HOW DID YOU HEAR ABOUT OUR CLINIC?**

( ) Internet ( ) Building Signage ( ) Phone book ( ) Brochure  
( ) Friend \_\_\_\_\_ ( ) Work Colleague \_\_\_\_\_  
( ) Medical Doctor \_\_\_\_\_ ( ) Family Member \_\_\_\_\_  
( ) Massage Therapist \_\_\_\_\_ ( ) Physiotherapist \_\_\_\_\_  
( ) Chiropractor \_\_\_\_\_ ( ) Other \_\_\_\_\_

Do you have extended health care insurance? Yes No If yes, with whom? \_\_\_\_\_

Have you received Chiropractic Care previously? Yes No

Reason for past Chiropractic Care \_\_\_\_\_

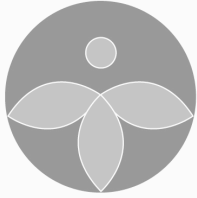
Results: Excellent Good Fair Poor

**ARE YOU CLAIMING?**

Worker Compensation Board Yes No Claim # \_\_\_\_\_ Adjustors Name: \_\_\_\_\_  
I.C.B.C Yes No Claim # \_\_\_\_\_ Adjustors Name: \_\_\_\_\_

**OTHER HEALTH CARE PRACTITIONERS TREATING YOU?**

( ) Massage Therapy ( ) Acupuncture ( ) Physiotherapy ( ) Naturopathic Doctor  
( ) Other: \_\_\_\_\_



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Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

**A** = Ache  
**B** = Burning  
**N** = Numbness  
**O** = Other  
**P** = Pins & Needles  
**S** = Stabbing

REASON(S) FOR TODAY'S VISIT:

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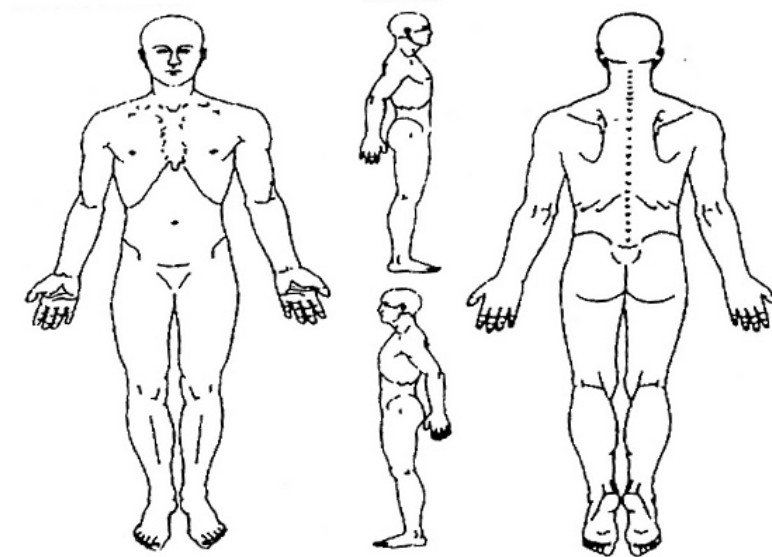
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Are your symptoms changing?

- ( ) Improving  
( ) Not Changing  
( ) Getting Worse



Have you undergone any surgeries? Yes No If yes, briefly describe

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Have you ever had any falls, injuries, car accident, traumas, head injuries, accidents? Yes No  
Describe

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Are you currently taking any medications (prescription or over the counter) Yes No

List: 

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Are you currently taking any vitamins, minerals or herbal supplements Yes No

List: 

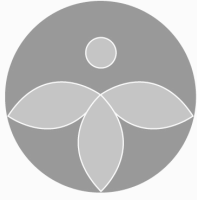
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When was your last physical exam? 

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Do you currently wear Custom – made Orthotics? Yes No If yes, how old are they? 

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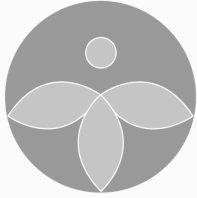
For Women:

Menstrual Problems: Yes No If yes, describe \_\_\_\_\_

Are you pregnant: Yes No If yes, expected due date \_\_\_\_\_

**Please mark with a “√” if you are currently experiencing or have experienced any of the following:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> headaches               | <input type="checkbox"/> general fatigue        | <input type="checkbox"/> sciatica             |
| <input type="checkbox"/> neck pain               | <input type="checkbox"/> depression             | <input type="checkbox"/> hay fever            |
| <input type="checkbox"/> jaw pain                | <input type="checkbox"/> slipped disc           | <input type="checkbox"/> migraines            |
| <input type="checkbox"/> pain between shoulders  | <input type="checkbox"/> difficulty swallowing  | <input type="checkbox"/> neck spasms          |
| <input type="checkbox"/> low back pain           | <input type="checkbox"/> anemia                 | <input type="checkbox"/> loss of weight       |
| <input type="checkbox"/> sinusitis               | <input type="checkbox"/> visual problems        | <input type="checkbox"/> night sweats         |
| <input type="checkbox"/> stroke                  | <input type="checkbox"/> ear infections         | <input type="checkbox"/> clicking in neck     |
| <input type="checkbox"/> dizziness               | <input type="checkbox"/> cold hands/feet        | <input type="checkbox"/> liver trouble        |
| <input type="checkbox"/> nausea                  | <input type="checkbox"/> stomach pain           | <input type="checkbox"/> excessive gas        |
| <input type="checkbox"/> loss of vision          | <input type="checkbox"/> heart burn/indigestion | <input type="checkbox"/> gall bladder stones  |
| <input type="checkbox"/> loss of taste/smell     | <input type="checkbox"/> loss of memory         | <input type="checkbox"/> painful urination    |
| <input type="checkbox"/> fainting spells         | <input type="checkbox"/> bladder infections     | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> loss of consciousness   | <input type="checkbox"/> ulcers                 | <input type="checkbox"/> aortic aneurysm      |
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> prostate problems      | <input type="checkbox"/> diarrhea             |
| <input type="checkbox"/> arthritis               | <input type="checkbox"/> blood disorders        | <input type="checkbox"/> constipation         |
| <input type="checkbox"/> allergies               | <input type="checkbox"/> diabetes               | <input type="checkbox"/> kidney problems      |
| <input type="checkbox"/> asthma                  | <input type="checkbox"/> cancer                 | <input type="checkbox"/> chest pain           |
| <input type="checkbox"/> shortness of breath     | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> heart attacks        |
| <input type="checkbox"/> pinched nerve           | <input type="checkbox"/> Thyroid Problems       |   |



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## CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

### CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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:

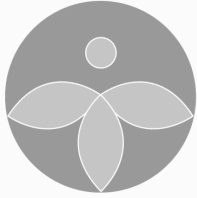
- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation 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





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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)

\_\_\_\_\_  
Signature of patient (or legal guardian)

\_\_\_\_\_  
Signature of Chiropractor

Date: \_\_\_\_\_ 20\_\_\_\_

Date: \_\_\_\_\_ 20\_\_\_\_