GAINSBOROUGH family CHIROPRACTIC

Patient Reactivation

Date: _____ / _____ / _____
Month Day Year

First name: _____ Last name: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Email: _____ Phone Number: _____

If you are not already receiving email updates, shall we add you to the list? ☐ Yes ☐ No

Your last visit to our office:

_____

Have you had any chiropractic care since then? ☐ Yes ☐ No

If you answered yes to the question above, please provide details.

_____

_____

_____

_____

Health History

1. To the best of your recollection, for what reason had you decided to leave our office and discontinue care?

_____

2. Please describe your health status since your last visit to our office including, visits to other doctors, hospital stays, medications and/or supplements, motor vehicle accidents and/or work related injuries.

_____

_____

_____

3. Have you had any major lifestyle changes since your last visit (e.g. wedding, children, employment)?

4. What is your reason for returning to our office?

Please circle your desired goal:

1. Optimization
continued health development

2. Maintenance
stabilize at your current level of health

3. Reversal
decreased health and function

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Informed Consent to Chiropractic Examination and Care

I hereby request and consent to receive chiropractic adjustments and other chiropractic procedures (if necessary), from the doctors of chiropractic in this clinic. I have had an opportunity to discuss with the doctors of chiropractic in this clinic the nature and purpose of chiropractic adjustments and care. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, there are some very slight risks associated with chiropractic care. Doctors of chiropractic and other health care practitioners who use spinal adjustment techniques are required to advise their patients of the following:

On rare occasions, some patients have reported rib fractures, muscle strains, ligament sprains, and disc injuries following spinal adjustments. However, no scientific study has ever verified such injuries. Spinal adjustments are rarely associated with vertebral artery injuries. Such injuries may cause stroke, sometimes with serious neurological impairment. The risk of injuries or complications from chiropractic care is very rare.

I do not expect the doctor to be able to anticipate and explain all risks and complications. During the course of my care, I wish to rely on the doctor to exercise judgment in my best interest, based upon the facts known at the time.

I have read the above consent. I have had an opportunity to ask questions about its content, and by signing below I agree to the above procedures. I intend this consent to apply to all my present and future care in this clinic.

_____
Print patient's full name

_____
Patient's (or guardian's) signature

_____
Witness to signature above

Date: _____ / _____ / _____
Month Day Year