



Dr. Peter Williams || 705-797-4977 || 250 Bayview Drive Barrie ON Unit #11 L4N 4Y8 || info@poweredbychiro.ca

Many times symptoms indicate a long standing spinal condition. Please check off any symptoms you have now or have experienced in the past.

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds/flu
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Concentration	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual pain
<input type="checkbox"/>	<input type="checkbox"/>	Arm/hand pain or numbness	<input type="checkbox"/>	<input type="checkbox"/>	Leg/foot pain or numbness
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Stroke

Please describe your symptoms or reasons for making this appointment:

How long have you had this condition? _____ Have
 you had a similar condition in the past? _____ What
 makes it worse? _____
 What relieves it? _____
 Do you feel your symptoms have been getting: better same worse?
 Is the pain: sharp dull burning tight throbbing numb?
 Is this condition interfering with your: work home routine family?
 What doctors have you seen about this condition? _____
 Have you seen a Chiropractor before? yes no When? _____
 Approximately how many visits? _____

INSURANCE

I understand that any insurance coverage is an arrangement between the insurance company and me. I understand that Powered By Chiropractic will prepare any necessary statements and forms to assist me in collecting from the insurance company. Furthermore, I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays, will be performed on you to minimize this risk to you. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor.

I have read the above statements and consent to treatment.

Signature: _____ **Date Signed:** _____