

**FAMILY FIRST CHIROPRACTIC**

6788 Thorold Stone Road  
Niagara Falls, Ontario  
L2J 1B4

Dr. Heather Robson-McInnis, D.C.

(ph) 905-358-8717  
(fx) 905-358-7951

**Adult Patient Update Form**

Name: \_\_\_\_\_

File #: \_\_\_\_\_

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

Has your address or phone number changed since your last visit? Yes or No

Address: \_\_\_\_\_

City: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Have you had any accidents or falls since your last visit? \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_

Do you wear orthotics? Yes or No

**CONSENT TO TREATMENT**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of diagnostic testing, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand that results are not guaranteed.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment including, but not limited to: muscle strains and sprains, disc injuries, and strokes. For example, in specific, the risk of stroke has been documented at approximately one in one million, to one in three million. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

\_\_\_\_\_  
Print Patients' Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Witness  
Dr. Heather Robson-McInnis

\_\_\_\_\_  
Date

[Type text]

PLEASE TURN OVER

**FAMILY FIRST CHIROPRACTIC**

6788 Thorold Stone Road  
Niagara Falls, Ontario  
L2J 1B4

Dr. Heather Robson-McInnis, D.C.

(ph) 905-358-8717  
(fx) 905-358-7951

Please circle any of the following you have had in the past 6 months:

**Musculo-Skeletal**

Low Back Pain  
Pain Between Shoulders  
Neck Pain  
Arm Pain  
Joint Pain/Stiffness  
Walking Problems  
Difficult Chewing/Clicking Jaw  
General Stiffness

**Nervous System**

Nervous  
Numbness  
Paralysis  
Dizziness  
Forgetfulness  
Confusion/Depression  
Fainting  
Convulsions  
Cold/Tingling Extremities  
Stress

**General**

Fatigue  
Allergies  
Loss of Sleep  
Fever  
Headaches

**Gastro-Intestinal**

Poor/Excessive Appetite  
Excessive Thirst  
Frequent Nausea  
Vomiting  
Diarrhea  
Constipation  
Hemorrhoids  
Liver Problems  
Gall Bladder Problems  
Weight Trouble  
Abdominal Cramps  
Gas/Bloating after meals

**Genito-Urinary**

Bladder Trouble  
Painful/Excessive Urination  
Discoloured Urine

**C-V-R**

Chest Pain  
Shortness of Breath  
Blood Pressure Problems  
Irregular Heartbeat  
Heart Problems  
Lung Problems/Congestion  
Varicose Veins  
Ankle Swelling  
Stroke

**EENT**

Vision Problems  
Dental Problems  
Sore Throat  
Ear Aches  
Hearing Difficulty  
Stuffed Nose

**Female**

Menstrual Irregularity  
Menstrual Cramps  
Vaginal Pain/Infection  
Breast Pain Lumps  
When was your last period: \_\_\_\_\_  
Are you pregnant? Yes No Not Sure

**Prostate/Sexual Dysfunction/Other problems:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History**

The following have a same or similar problem as I do: Mother Father Sister Brother Spouse Child

[Type text]

PLEASE TURN OVER