



Stibbard Chiropractic
6975 Wyandotte St. E,
Windsor, On, N8S 1P8
Phone: (226) 506-2681
stibbardchiropractic@gmail.com
stibbardchiropractic.com

Name: _____ DOB: _____

Gender: Male Female Other: _____

Address: _____

City: _____ Province: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Medical Dr. Name: _____ Date of last physical: _____

Previous Chiropractor Name: _____

Permission to Contact above health care providers: Y N

How did you hear about our clinic?: _____

Private Insurance Provider: _____

Policy #: _____ Member #: _____

Name of card holder: _____

Relationship to card holder: _____

Is this a workplace injury or a motor vehicle accident?: _____ Claim Number: _____



Stibbard Chiropractic
 6975 Wyandotte St. E,
 Windsor, On, N8S 1P8
 Phone: (226) 506-2681
stibbardchiropractic@gmail.com
stibbardchiropractic.com

Please check the appropriate box for any of the following symptoms, which you have now or have had previously

C = Constant

F = Frequent

O = Occasional

NEUROLOGICAL	C	F	O	EYES, EARS, (CONTD)	C	F	O	SKIN	C	F	O
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Far Sighted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENTO-URINARY	C	F	O
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near Sighted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urine Control Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								Prostate Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE AND JOINT	C	F	O	CARDIO-VASCULAR	C	F	O	Pus in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smell of Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PAIN/NUMBNESS IN	C	F	O
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of Arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Over Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY	C	F	O	GASTROINTESTINAL	C	F	O	Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burping or Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Tailbone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FOR WOMEN ONLY	C	F	O
				Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES, EARS, NOSE AND THROAT	C	F	O	Difficult Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distension of Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Decay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Ear Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Last Menstruation Date:			
Ear Noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Due Date:			
				Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				



Stibbard Chiropractic
6975 Wyandotte St. E,
Windsor, On, N8S 1P8
Phone: (226) 506-2681
stibbardchiropractic@gmail.com
stibbardchiropractic.com

List of All Current Medications:

Previous Chiropractic Care: _____

Allergies: _____

Surgeries: _____

Hospitalizations: _____

Infections: _____

Check all that apply- Do you have a family history of:

Cancer _____ Diabetes _____ High Blood Pressure _____ Heart Disease _____ Stroke _____

Arthritis _____ Other: _____

Check all that apply- Have you experienced any recent:

Unexplained weight loss _____ Fever or night sweats _____ Fatigue/Malaise _____

Loss of appetite _____ Night pain _____

Hours of Physical Activity per week: _____ If you're pregnant, how many weeks?: _____

If you smoke, how many cigarettes per day?: _____

If you drink alcohol, how many drinks per week?: _____



Stibbard Chiropractic
6975 Wyandotte St. E,
Windsor, On, N8S 1P8
Phone: (226) 506-2681
stibbardchiropractic@gmail.com
stibbardchiropractic.com

INFORMED CONSENT FOR ACUPUNCTURE CARE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits

Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks

The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Are Immune compromised
- Have a bleeding disorder or take anticoagulants
- Suffer from metal allergies
- Have damaged heart valves or have a high risk of infection
- Have been fitted for a pacemaker or other electrical implants
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.



Stibbard Chiropractic
6975 Wyandotte St. E,
Windsor, On, N8S 1P8
Phone: (226) 506-2681
stibbardchiropractic@gmail.com
stibbardchiropractic.com

Pregnancy

The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives

Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

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.**

I hereby acknowledge that I have read this form and 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 acupuncture treatment as proposed to me.

Today's Date: _____

Patient Name (Please Print)

Witness Name

Patient Signature (or Legal Guardian)

Witness Signature



Stibbard Chiropractic
6975 Wyandotte St. E,
Windsor, On, N8S 1P8
Phone: (226) 506-2681
stibbardchiropractic@gmail.com
stibbardchiropractic.com

CONSENT TO CHIROPRACTIC TREATMENT

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.



Stibbard Chiropractic
6975 Wyandotte St. E,
Windsor, On, N8S 1P8
Phone: (226) 506-2681
stibbardchiropractic@gmail.com
stibbardchiropractic.com

• **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

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.

I hereby acknowledge that I have read this form and 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.

Today’s Date: _____

Patient Name (Please Print)

Witness Name

Patient Signature (or Legal Guardian)

Witness Signature