Dr. Gillian Sawyer
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drgilliansawyer@gmail.com

Patient Information

Date: _____ Alberta Health Care Number: _____
First Name: _____ Last Name: _____
Date of Birth (M/D/Y): _____ Age: _____ Gender pronoun:_____
Address: _____
City: _____ Province:_____ Postal Code: _____
Phone (h)_____(c)_____ (w) _____
Occupation : _____
Email:_____

How did you hear about Dr. Gillian @ShifraWellness?

Referral:_____ (OBGYN/Midwife/Doula/Friend etc)
Other: _____(google/facebook/instagram/sign/drive by)

Health Care Providers

Family Doctor: _____ OBGYN/Midwife: _____
Acupuncturist: _____Naturopath:_____ Massage Therapist: _____
Physiotherapist: _____ Other Care Providers: _____

*Would you like a follow-up letter regarding your exam findings/care plan sent to your doctor? Y / N

Motor Vehicle Accident / Work related (if applicable)

Is this condition related to: Work? □ Yes □ No Has your employer been notified? □ Yes □ No
Motor vehicle accident? □ Yes □ No Date of injury: _____
Have you seen another practitioner in regards to this accident? Y/N
Practitioner Name: _____
Insurance Company: _____ Phone number: _____ Claim #: _____

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Perinatal Questionnaire

Pregnancy profile – please check/circle/fill in the following information to give me a detailed picture of your pregnancy.

I am in my 1st/2nd/3rd trimester
I am _____ weeks My Due Date is _____
I am planning to have my birth at _____
This is my (1st/2nd/3rd /4th …?) _____ pregnancy
I am under the care of the following health care providers (OBGYN/Midwife/Doula)
_____
Have there been any issues/medical concerns with any of your check-ups so far? If so please explain
_____
_____

I am currently experiencing the following: (please circle applicable items)
Nausea / vomiting / dizziness
Fatigue
Stress / worry / fear
Sleep disturbance
Swelling
Cramping
Spotting
Gestational Diabetes
High/ Low Blood Pressure
Shortness of breath
Difficulty walking/sitting/standing

Pain:
Under the ribs;
In my low back/pelvis/pubic bone
On the sides of my hips
In my arms / legs
In my neck
Across my shoulders/between my shoulder blades
Tension/pulling under my belly
Other (please explain)
_____
_____
_____

The position of my baby is: Head down / Transverse / Breech / Unknown

The position of my placenta is: Fundal/ Previa/ Unknown

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Please describe your **previous birth experience** if applicable (1st, 2nd, 3rd….)_____

Vaginal delivery / C-section

Vacuum / Forceps / Episiotomy

Induction at week_____ method of induction: _____

Length of labour _____

Baby weight _____ length _____

Breastfeeding issues /challenges _____

Please describe any **Postpartum concerns**:_____

*Medical issues following delivery:_____

*Postpartum Depression/Anxiety/other :_____

*Pelvic Floor Issues: heaviness, incontinence, painful intercourse, prolapse, other:
_____

*Were you assessed by a Pelvic Floor Physio or other Health Professional postpartum (please explain:_____

*Do you have any specific concerns you'd like to address?

_____

*Would you like more information about :

Prenatal/Postnatal/Pediatric Chiropractic Care/ Acupuncture / Massage / Nutrition / Yoga / Counseling / Doula support/ Postpartum support / lactation consulting / Prenatal classes / Other resources:
_____
_____

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Current Health Condition

*Reason for this appointment/major complaint:_____

_____

*How did this compliant occur:

_____

*When did your condition begin: _____days /weeks /months/years
*Have you had this condition before: Y/N
*Is your condition getting: Better/ Worse/ No change
*Symptoms came on: Suddenly / Come & Go

*Indicate the **severity** of the **pain** by circling one of the following numbers:

(No Pain) *0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *(Extreme Pain)*

*Please use the symbols below to mark on the pictures where you are experiencing your current pain.

Numbness = = =

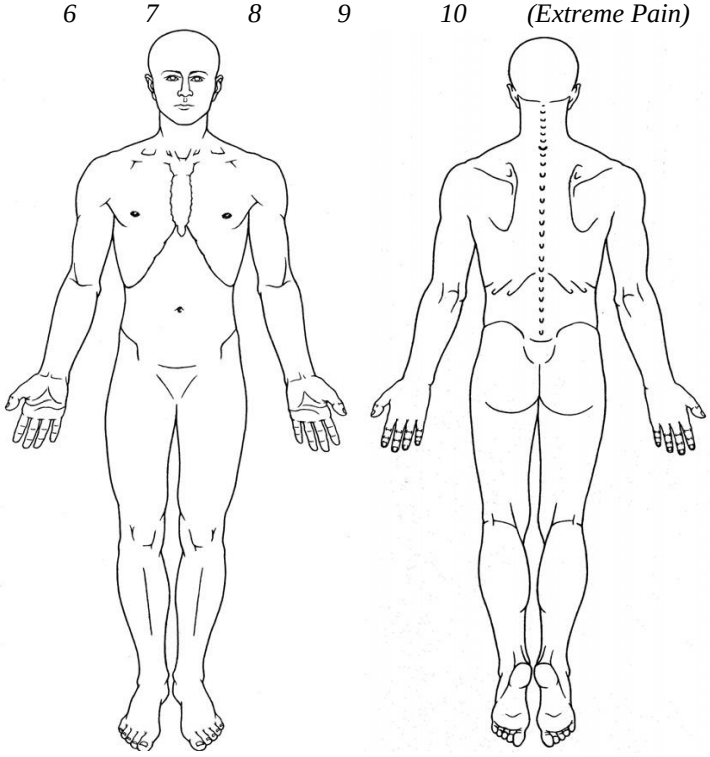
Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^



*Describe the character of your pain: (dull & achy, sharp/stabbing, shooting, throbbing)

_____

*What activities make this condition <u>better</u>? (ice, heat, stretching, resting):

_____

*What activities make this condition <u>worse</u>? (activity, certain movements, prolonged standing/sitting):

_____

*Have you experienced radiating pain/ numbness/ tingling/ weakness since your condition began. If so please specify where:_____

*Symptoms are BETTER in: AM / midday / PM/ Do not change with time of day
*Symptoms are WORSE in: AM / midday / PM / Do not change with time of day

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*Can you perform your daily activities: Y/N/some
*Can you perform your daily work activities: Y/N/some

*Have you seen other Doctors/Health Care Providers for this condition?:
_____

*Please list ALL medications/supplements you are taking (prescriptions, vitamins, herbal supports, BCP, aspirin etc):_____
(for what conditions- _____

*Have you had previous Chiropractic Care: Y/ N Doctor: _____Date:_____

Habits:

Caffeine: cups/days: _____ Smoking: packs/day: _____ Alcohol: drinks/wk: _____

Sleep: hours/night: _____ Exercise: none/moderate/daily What kind: _____

Stress level: none /mild /moderate /high

Past Health History:

Have you ever been diagnosed with any of the following:

*High blood pressure: Y/N *Hardening of arteries (arteriosclerosis): Y/N *Diabetes: Y/N

*Heart/blood disease: Y/N *Stroke: Y/N *Arthritis: Y/N

*Fibromyalgia: Y/N *Cancer: Y/N _____ *Other conditions:_____

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List any **Surgeries**:_____
List any **Hospitalizations**:_____
List any **Accidents/Falls**:_____

Family History:

Is there a **history in your family** of cancer, diabetes, heart attack, high blood pressure, stroke, arthritis or neck/back pain?
Father_____Mother_____Siblings_____Grandparents:_____

SYSTEMS REVIEW: Please **CHECK** any of the following conditions you are experiencing **currently** and **UNDERLINE** those you have experienced in the **past**:

GENERAL SYMPTOMS
- ☐ Fever
- ☐ Sweats
- ☐ Fainting
- ☐ Sleep disturbance
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight loss
- ☐ Weight gain

NEUROLOGICAL
- ☐ Visual disturbance
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions
- ☐ Headache
- ☐ Numbness
- ☐ Neuralgia (nerve pain)
- ☐ Poor coordination
- ☐ Weakness

MUSCLE & JOINT
- ☐ Neck pain
- ☐ Low back pain
- ☐ Arm pain
- ☐ Shoulder pain
- ☐ Leg pain
- ☐ Knee pain
- ☐ Foot pain
- ☐ Pain/numbness in arms/legs
- ☐ Pain between shoulders
- ☐ swollen joints
- ☐ Spinal curvature
- ☐ Arthritis
- ☐ Fractures

RESPIRATORY
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Asthma

CARDIOVASCULAR
- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Hardening of arteries
- ☐ Swollen ankles
- ☐ Poor circulation
- ☐ Palpitations
- ☐ Cold hand or feet
- ☐ Varicose veins

EARS/EYES/NOSE/THROAT
- ☐ Eye pain
- ☐ Double vision
- ☐ Ringing in ears
- ☐ Deafness
- ☐ Nosebleeds
- ☐ Trouble swallowing
- ☐ Hoarseness
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands

GENITOURINARY
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection
- ☐ Prostate trouble
- ☐ Uncontrollable urine flow

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Difficult digestion
- ☐ Heartburn
- ☐ Ulcers
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Gallbladder/jaundice
- ☐ Colitis/Chrohns

FOR WOMEN ONLY
- ☐ Painful menstruation
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or back pain
- ☐ Vaginal discharge
- ☐ Nipple discharge
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Birth control pills
- ☐ Miscarriages
- ☐ Complications with pregnancy

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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.

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- 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.

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.

_____ Date: _____ 20____.

Name (Please Print)

_____ Date: _____ 20____.

Signature of patient (or legal guardian)

_____ Date: _____20____

Signature of Chiropractor