

Kay Chiropractic & Wellness Centre
Consent for Physical Examination

Dr. Glen Bell, B.Sc., N.D.

1. Please initial all items of the physical that you give consent to be examined.
2. All items you do not give consent to, please indicate with an "N".
3. Please leave blank any item you would like to discuss with Dr. Bell.

- ___ **Head:** inspect (look), palpate (touch), passive range of motion (ROM)
- ___ **Eyes:** inspect, palpate
- ___ **Ears:** inspect, palpate, look inside the ears
- ___ **Nose:** inspect, palpate, look inside the nose
- ___ **Mouth:** inspect, look inside, use tongue depressor to inspect throat, palpate TMJ
- ___ **Neck:** inspect, palpate, ROM, **Thyroid:** inspect, palpate
- ___ **Lymph nodes:** palpate – neck, head, underarm, groin
- ___ **Chest (front):** inspect, palpate, listen to heart and lungs **Respiratory Rate** ___
- ___ **Back, spine:** inspect, palpate, listen to lungs, ROM
- ___ **Abdomen:** inspect, listen, palpate, locate liver and spleen below the rib cage
- ___ **Neurological:** reflexes (knees, wrists, elbows, ankles, abdomen), neurological tests
- ___ **Skin:** inspect, palpate (where applicable)
- ___ **Extremities:** including hands, feet, elbows, shoulders, legs: inspect, palpate, ROM
- ___ **Blood Pressure:** Left arm and Right arm ___ Heart Rate ___ Pulse Rate
- ___ **Breast exam:** inspection, palpate
- ___ **Genital exam:** inspection ___ External exam ___ Internal exam
- ___ **Prostate exam**
- ___ **Rectal exam:** ___ External exam ___ Internal exam

I give informed consent to the above physical examination procedures that are initialed.

Signature

Print name

Date

Kay Chiropractic & Wellness Centre

Dr. Glen Bell, B.Sc., N.D.

Name: _____

Date: _____

Date of Birth: M/ D/ Y/ _____ Age: _____

Sex: M F

Address: _____

Phone: (home) _____

City/ Postal code: _____

(work) _____

(cell) _____

Occupation: _____

Employer: _____

Emergency Contact Name and Phone number: _____

How did you discover the clinic and Dr. Bell? Referred by: friend, family, health professional or yellow pages (circle one)

Have you seen a Naturopathic Doctor before? _____

Other Health Care Providers (MD, DC, RMT, DDS, Physiotherapist, Psychotherapist, Other):

Name			
Phone Number			

In order of importance to you, what are your health concerns or goals?

1. _____
2. _____
3. _____
4. _____

Medical History

Are there any ethical, religious, or cultural considerations that may interfere with your treatment that Dr. Bell should be aware of? _____

Please indicate any serious conditions, illnesses or injuries, surgeries, hospitalizations and traumas (emotional and physical). Please include dates: _____

Do you have any allergies or adverse reactions to foods, medications, and/or environmental? Please explain: _____

How many times have you taken antibiotics in the past 5 years? _____

Please circle if you have had any of the following tests. Please indicate date.

Allergy test	Urine analysis	Blood pressure	Cholesterol
x-rays	Ultrasound	MRI	CAT scan
Blood tests	PSA	Prostate exam	Colonoscopy
Breast exam	Gynecological exam	Pap smear	Vision test
Hearing test	Homocysteine	Other:	

Please list all current medications, over-the-counter medications and supplements:

Prescription	Over-the-counter	Nutritional supplements	Herbal Medicines	Homeopathic Remedies

Do you frequently or occasionally use any of the following? Please circle and indicate how often:

Aspirin	Tylenol	Antacids	Diuretics
Diet pills	Sleeping pills	Hormones	Caffeine
Alcohol	Tobacco	Recreational drugs	Other:

Please indicate if have any of the following conditions:

Eczema/Psoriasis	Bowel disease	Gallstones	Parasites	Hepatitis
Asthma	Tuberculosis	Arthritis	Osteoporosis	Kidney disease
Heart disease	High BP	Stroke	Bladder infections	Kidney stones
Mononucleosis	Infertility	Miscarriages	Yeast infections	Prostate cancer
Breast cancer	Alcoholism	Depression	Eating disorder	Abuse
Insomnia	Migraines	Anemia	Diabetes	Epilepsy

Lifestyle

How often do you exercise per week? _____

What do you do for exercise? _____

Please rate your stress level at home, work and other aspects of your life, on a scale of 1-10: _____

Please list the two most stressful events in your life (from most recent to most distant):

1. _____ 2. _____

Please rate the emotional climate of your home: Excellent Good Fair Poor

Is there anything you feel important to disclose that has not been asked? _____
