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Winkler, MB R6W OH5
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Dr. Joe Suderman
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Patient Intake Form

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Cell Phone Number: _____ Home Phone Number: _____

Email: _____ Occupation: _____

Date of Birth (D/M/Y): _____ /_____ /_____ Referred By_____

MB Health (6 Digit #): _____ MB Health (9 Digit #):_____

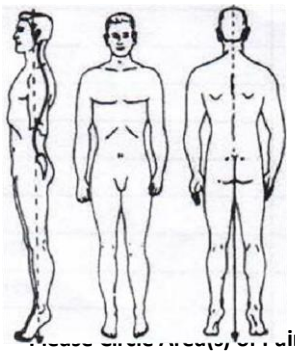
What symptom(s) brought you in today?

1.) _____ When did it start? _____ Intensity: _____ /10
□ Sharp □ Stabbing □ Dull □ Achy □ Throbbing □ Numb □ Tingling Radiates (if yes, to where)? _____

2.) _____ When did it start? _____ Intensity: _____ /10
□ Sharp □ Stabbing □ Dull □ Achy □ Throbbing □ Numb □ Tingling Radiates (if yes, to where)? _____

3.) _____ When did it start? _____ Intensity: _____ /10
□ Sharp □ Stabbing □ Dull □ Achy □ Throbbing □ Numb □ Tingling Radiates (if yes, to where)? _____

Is your problem as a result of: □ Auto Accident □ Work Accident □ Slip & Fall



Aggravating Factors:

□ Cough □ Sneeze □ Lifting □ Bending □Twisting
□ Sitting □ Standing □ Walking □ Driving
□ Stairs Up □ Stairs Down □ Getting Up From Chair
□ Getting In/Out of Car

Relieving Factors:

□ Ice □ Heat □ Massage □ Stretching
□ Sitting □ Standing □ Laying Down
□ Other: _____
_____

Please Circle Area(s) of Pain

Previous Treatments: □ Chiropractic □ Physiotherapy □ Massage □ Other: _____

Motor Vehicle Accidents: □ Yes □ No Injury date: _____ MPI Claim #: _____

Is this a WCB case? □ Yes □ No Injury date: _____ WCB Claim #: _____

Surgeries: □ Yes □ No When: _____

Fall on Tailbone: □ Yes □ No When: _____ Hit to the Head □ Yes □ No When: _____

Slips and/or Falls: □ Yes □ No _____ When: _____

Do you play or have you previously played any sports? □ Yes □ No Details: _____

Previous Diagnosis:

□ Arthritis □ Cancer □ Hypertension □ Diabetes □ Heart Disease □ Skin Disorder □ Depression □ Anxiety
□ Fibromyalgia □ TMJ □ Disk Herniation □ Allergies □ Lung Disorder □ Stroke □ Osteoporosis

Hereditary Factors (Family History): _____

_____

Medications: _____

_____

Please Mark All that Apply Currently:

□ Blood Pressure High/Low
□ Chest Pain
□ Palpitations
□ Swelling
□ Neck Pain
□ Arm Problems
□ Pain Between the Shoulders
□ Low Back Problems
□ Leg Pain
□ Painful Joints
□ Stiff Joints
□ Sore Muscles
□ Weak Muscles
□ Rupture of Tendons
□ Loss of Memory
□ Problems Concentrating
□ Kidney Stones

□ Bladder Trouble
□ Constipation
□ Diarrhea
□ Heartburn
□ Vomiting/Nausea
□ Abdominal Pain
□ Hemorrhoids
□ Allergies
□ Coughing
□ Shortness of Breath
□ Asthma
□ Sinus Problems
□ Headaches
□ Ringing in the Ears
□ Hearing Loss
□ Ear Pain
□ Vision Problems

□ Jaw Problems
□ Gout
□ Numbness
□ Dizziness
□ Fainting
□ Muscle Spasms
□ Varicose Veins
□ Walking Problems
□ Broken Bones
□ Easy Bruising
□ Thyroid Problems
□ Lung Problems
□ Liver Problems
□ Prostate Problems
□ Gall Bladder Problems
□ Fatigue
□ Sore Throat

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Updated: September 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the- counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

_____
Patient Name (print)

_____	_____	_____
Patient/Guardian Signature	Date	Chiropractor Signature