



SOURCE CENTRE  
HEALTH IN WHOLENESS

## Network Spinal Analysis - Patient Intake Form

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ M / F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov. \_\_\_\_\_  
Postal code : \_\_\_\_\_ Phone (home): \_\_\_\_\_ work: \_\_\_\_\_  
cell: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Date of birth (d/m/y) \_\_\_\_\_ # Of Children: \_\_\_\_\_ Occupation: \_\_\_\_\_

I hereby give my consent to Source Centre to contact me via e-mail or to leave phone messages regarding my care at the above numbers.

Family Doctor: \_\_\_\_\_ Doctor's Address \_\_\_\_\_

I hereby give my consent to Dr. Sutherland to inform my family Doctor that I am under her care.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

How did you discover our office and the professional services we offer? \_\_\_\_\_

### Your Health Concerns or Symptoms and How They May Affect Your Life

Do you have a current health concern? Please describe: \_\_\_\_\_

When did this situation or concern begin? \_\_\_\_\_

Have you done anything about this situation or gotten any advice or treatment for it? Yes  No

If yes, what were you told? \_\_\_\_\_

What was done? \_\_\_\_\_

Did it seem to work? \_\_\_\_\_

Please grade the level to which this health concern affects these aspects of your life

X = does not affect me                      ✓ = affects me somewhat  
✓✓ = affects me moderately              ✓✓✓ = affects me drastically

___ effect on work	___ effect on recreation/play	___ effect on rest/sleep
___ effect on social life	___ effect on walking	___ effect on sleeping
___ effect on exercise	___ effect on eating	___ effect on love life
___ concern about particular symptom/condition		___ concern about health
___ effect during the daytime	___ effect at nighttime	

Is there anything that makes this concern worse? \_\_\_\_\_

Is there anything that makes this concern better? \_\_\_\_\_

Why do you think this is happening or continues to happen to you? \_\_\_\_\_

If this symptom were to go away tomorrow what would be different about your life? \_\_\_\_\_

What are you doing in your life now that is different than if you did not have this concern? \_\_\_\_\_

Please mark the statement that you feel best describes your current feelings about yourself and your situation.

- I feel helpless, like little or nothing works
- I feel terrible, really bad, I am scared, and hope that you can fix me.
- I feel stuck, and I can't help myself right now.
- I deserve more than what I've been experiencing, and would like you to assist me in my healing.

## Physical History

Each of these has potential to stress your nervous system. Please indicate which plays a role in your life either presently or in the past.

	Mild		Moderate		Extreme	
	Past	Present	Past	Present	Past	Present
Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports impacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical/sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeated postural stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood injuries/Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Vehicle Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check yes or no to the following questions. If you check yes, please explain.

Have you ever been knocked unconscious? Yes  no  \_\_\_\_\_

Have you ever used crutches, a cane or a walker? Yes  no  \_\_\_\_\_

Have you ever broken any bones? Yes  No  \_\_\_\_\_

Have you ever had an impact, fall or jolt that may have injured your spine? Yes  No  \_\_\_\_\_

Have you ever been hospitalized? Yes  No  \_\_\_\_\_

Have you had surgery? Yes  No  \_\_\_\_\_

Have you had?  Spinal x-rays  Cat scans  MRI imaging  Spinal brace  Neck collar  
 Heel lift  Orthotics  Traction  Spinal Tap  Traction

During the day do you sit  stand  Do phone work  do deskwork   
drive  walk  mechanical work  heavy lifting

## Chemical History

Please grade any dietary selection that is appropriate for you using the following scale

X = do not consume this

✓ = consume this rarely

✓✓ = consume this weekly

✓✓✓ = consume this daily or more

___ alcohol	___ fried foods	___ beef
___ coffee	___ cooked, canned vegetables	___ poultry
___ tobacco	___ dairy (milk products)	___ fish
___ artificial sweeteners	___ eggs	___ seafood
___ soft drinks	___ whole grains	___ fasting
___ diet food	___ fruit	___ organic foods
___ refined sugar	___ raw vegetables	___ vitamins/ supplements

Do you or did you work with any chemical, fume, dust, powder, smoke etc. for long periods?

Please list any medications you are presently using \_\_\_\_\_

Please list any herbs, nutritional supplements or natural remedies you take regularly \_\_\_\_\_

## Emotional History

	Mild		Moderate		Extreme	
	Past	Present	past	present	past	present
Childhood stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of a loved one being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work related stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of commuting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of a loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in life-style	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in career	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse(emotional/physical/sexual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there some aspect of your life that very much pleases you, brings you joy, or helps you to feel better about yourself? \_\_\_\_\_

When you are stressed, how do you "Center" yourself or "Re group" ? \_\_\_\_\_

## Previous Therapeutic Modalities

Have you had experience with any of the following health, treatment or healing modalities? If so, please describe when you went, for how long you went and the results:

- Ayurvedic medicine \_\_\_\_\_
- Bodywork/ Massage \_\_\_\_\_
- Breathwork \_\_\_\_\_
- Emotional Therapy/ Psychotherapy \_\_\_\_\_
- Homeopathy/ Herbalist \_\_\_\_\_
- Meditation/ Prayer \_\_\_\_\_
- Movement/ Exercise \_\_\_\_\_
- Music/ Sound/ Light/ Aromatherapy \_\_\_\_\_
- Nutritional Counseling/ Therapy \_\_\_\_\_
- Oriental Medicine/ Acupuncture \_\_\_\_\_
- Osteopathy/ Cranial Work \_\_\_\_\_
- Somato Respiratory Integration \_\_\_\_\_
- Yoga/ Movement/ Dance/ Tai Chi/ Chi Gong \_\_\_\_\_
- Other: \_\_\_\_\_

Has your spine ever been professionally adjusted? Yes  No

How long ago? And by whom? \_\_\_\_\_

Why did you go? \_\_\_\_\_

Are you still going? \_\_\_\_\_

Were you pleased? \_\_\_\_\_

Does your family receive Chiropractic care? \_\_\_\_\_

What would motivate you to tell others about the care you receive in this office, and encourage others to receive care? \_\_\_\_\_

# Informed Consent to Wholistic Spinal Care

Dr. Sutherland and Dr. Quan practice Wholistic Spinal Care, a unique approach to caring for you as a whole person. Dr. Sutherland and Dr. Quan utilize Network Spinal Analysis (NSA), a safe and gentle chiropractic technique consisting of gentle manual contacts along the spinal tissues. NSA enables the nervous system to release stored tension, enhancing your body's ability to heal itself.

I hereby request and consent to the performance of Wholistic Spinal Care and other chiropractic procedures, on me, by Dr. Sutherland and Dr. Quan. I also understand that the results of such treatment are not guaranteed.

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatments. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques.
- b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present scientific and medical evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Due to the utilization of other gentle methods, Dr. Sutherland and Dr. Quan will ask for your consent if manual adjustments are required.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I have read the above consent. I have had the opportunity to ask questions about its content, and by signing below, I agree to the included procedures. I intend this Consent to cover the entire course of my treatment plan.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient (or legal guardian)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Name of Witness (please print)