Patient Characteristics con't – Please describe what was known *PRIOR TO* treatment

6) Has the patient experienced an adverse event to manual therapy in the past?
☐ Yes ☐ No ☐ Unknown

If Yes, please specify _____

7) Did the patient have any other diagnoses? ☐ Yes ☐ No ☐ Unknown

If Yes, please specify _____

8) Were you aware if the patient had any of the following conditions **prior to treatment:**

☐ Acute infection	☐ High cholesterol	☐ Recent relevant trauma
☐ Alcoholism	☐ History of cancer	☐ Recent upper respiratory infection
☐ Arteriosclerosis	☐ History of TIA	☐ Spinal stenosis
☐ Bleeding tendency	☐ History of stroke	☐ Smoking
☐ Connective tissue disorder	☐ Hypertension	☐ Tuberculosis
☐ Degenerative disc disease	☐ Migraine	☐ Vertigo
☐ Diabetes	☐ Osteoporosis/Osteopenia	☐ Fever
☐ Fracture	☐ Prior spine surgeries	☐ Pregnancy
	☐ Radiculopathy	☐ Other

9) Please check medication(s) or natural health product(s) the patient was taking **prior to treatment:**

Prescription Medications ☐ Don't Know	**Natural Health Products**	☐ Don't Know
☐ Anticoagulant (warfarin, dicumarol)	☐ Garlic	☐ Vitamin K
☐ Antiplatelet (aspirin)	☐ Ginger	☐ Other NHP,
☐ Oral Contraception	☐ Ginkgo	Specify
☐ Steroid	☐ Omega 3 Fatty Acids	
☐ Other, specify _____	☐ Vitamin E	

Outcome (*from your perspective/awareness)*

Patient Impact:

10) What activities of daily living were affected?

11) Was self-care affected? ☐ Yes ☐ No ☐ Unknown

12) Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown

13) Describe any residual effect/permanent disability/death:

14) Did the adverse event require treatment? ☐ Yes ☐ No ☐ Unknown

15) Has the adverse event resolved? ☐ Yes ☐ No ☐ Unknown

If Yes, Date of Resolution *(dd/mm/yyyy)* _____ / _____ / _____

Provider Impact:

16) Has this event caused you to make any changes to your practice? ☐ Yes ☐ No

If Yes, describe

_____

17) Were there factors that could have minimized/prevented this event? ☐ Yes ☐ No

If Yes, describe: