Welcome to our Chiropractic Clinic:

Patient Information: *Please Print*

Name ________________________________ Consultation Date D/M/Y ____ /____ / ____

Age _______ D.O.B D/M/Y ____ / ____ / ____ Gender M/F _____ Height ______ Weight ______

Shoes Size ______ Marital Status ____________________ Number of Children __________

Occupation ___________________________ Family Doctor ________________________

Address ______________________________ City ____________Postal Code __________

Phone *Home* __________________*Work* ____________________ *Cell* ________________

Email ____

Other family members under care ____

Who can we thank for referring you? ____

Health Profile

It is a pleasure to welcome you to our family of happy and healthy Chiropractic patients. Our clinic offers many health services, but we have a focus: to reduce interference to the innate ability of the body to heal itself**.**

"Subluxations", or problems with joint alignment and motion, are conditions that Chiropractors are trained to detect and correct. Dysfunction within the body can be the *result* of subluxations in the spine and their effect on nerve supply. Often other symptoms are seen years before neck or back pain is noticed. It is for this reason we ask a wide variety of questions regarding your health. On a daily basis we experience physical, chemical, and emotional stress that can lead to subluxation. To help us serve you better, please complete the following information.

Consultation

Reason for seeking Chiropractic care? ____

____

Is this a work-related injury and you were hoping compensation for your care involve WSIB?

○ Yes ○ No

Is this concern: ○ Occasional ○ Frequent ○ Constant ○ Intermittent ○ Other: _____

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Consultation *(cont.)*

When did this begin? ____

What makes it better? ____

What makes it worse? ____

Is it worse during a certain time of day? ○ Yes ○ No If yes, when? _______________

Have you seen another health professional for help with this? ○ Yes ○ No

Who? ____

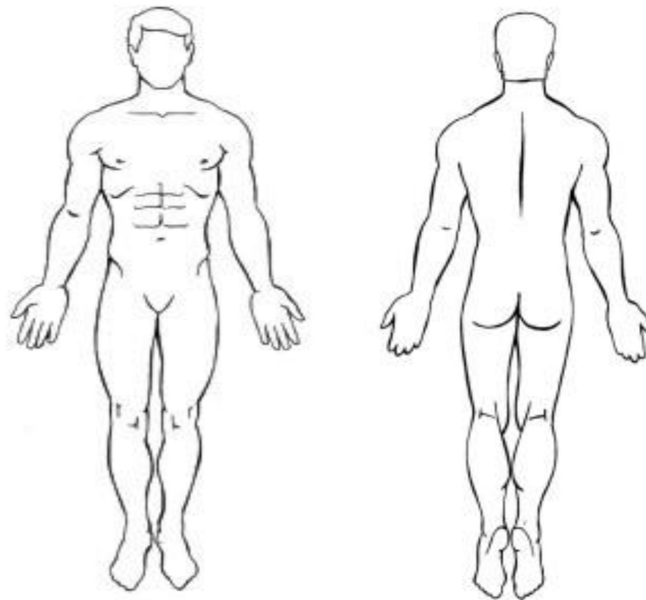
Treatment results? ____

Does this concern interfere with your:

○ Work ○ Sleep ○ Leisure ○ Attitude
○ Hobbies ○ Caretaking ○ Responsibility ○ Sports

What specifically does this concern prevent you from doing? ___________________________
____

Please outline on the diagram the area of your concern:



Any previous Chiropractic Care? ○ Yes ○ No What Doctor? ___________________

Approximate date of your last visit? D/M/Y ____ / ____ / ____

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Physical Stress *(falls, accidents, work posture, sport participation, etc.)*

Have you ever had a concussion? ○ Yes ○ No When? ______________________

Have you ever broken any bones? ○ Yes ○ No

Which ones and when? ____

Please list any health conditions you have been diagnosed with: ______________________

____

Have you had X-rays of the spine done? ○ Yes ○ No If yes, when and what area?

____

Were you standing for those X-rays? ○ Yes ○ No

Have you had any X-rays/CT/MRI/Ultrasound in your life? ○ Yes ○ No

When and on what area? ____

Do you wear orthotics? ○ Yes ○ No If so how old? __________________________

Have you had any surgery? *Please list all surgeries* ***Including childhood***

1. Type ________________________________ Date M/D/Y _____ / _____ / _____
2. Type ________________________________ Date M/D/Y _____ / _____ / _____
3. Type ________________________________ Date M/D/Y _____ / _____ / _____

Have you had any accidents and/or injuries? *Please list all accident/injuries* ***Including childhood***

1. Type ________________________________ Date M/D/Y _____ / _____ / _____
2. Type ________________________________ Date M/D/Y _____ / _____ / _____
3. Type ________________________________ Date M/D/Y _____ / _____ / _____

Chemical Stress *(smoking, unhealthy foods, missed meals, don’t drink enough water, alcohol, drugs, etc.)*

Do you smoke? ○ Yes ○ No

Please list any medications (pharmaceutical drugs) you are taking and for what condition

1. ______________________________ Condition ___________________________
2. ______________________________ Condition ___________________________
3. ______________________________ Condition ___________________________

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Chemical Stress *(cont.)*

Please list all supplements, minerals, vitamins and what brand they are

1. ______________________________ Brand ______________________________
2. ______________________________ Brand ______________________________
3. ______________________________ Brand ______________________________
4. ______________________________ Brand ______________________________
5. ______________________________ Brand ______________________________

Please rate your overall chemical stress

No Stress *Extreme Stress*

1 2 3 4 5 6 7 8 9 10

Emotional Stress *(Self-Esteem, relationships, work, etc)*

Please rate your stress level by circling the appropriate number.

Mindset

No Stress *Extreme Stress*

1 2 3 4 5 6 7 8 9 10

Quality of Sleep

No Stress *Extreme Stress*

1 2 3 4 5 6 7 8 9 10

Past Health History

Please list any hospitalizations and their reason (other than surgeries listed in page 3)

____

____

Please note any health issues (i.e. cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Parents: ____

Siblings: ____

Have your children ever had a spinal check-up? ○ Yes ○ No

If yes, where and when? ____

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General Health History

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Please mark the circles indicating any of the following conditions you have or have had:

Nervous System

- ○ Anxiety
- ○ Numbness
- ○ Paralysis
- ○ Dizziness
- ○ Forgetfulness
- ○ Confusion/Depression
- ○ Fainting
- ○ Convulsions
- ○ Stress
- ○ Cold/Tingling Extremities

Musculo-Skeletal

- ○ Low back pain
- ○ Gas/Bloating after meals
- ○ Pain between shoulders
- ○ Heartburn
- ○ Neck pain
- ○ Black/Bloody Stool
- ○ Arm Pain
- ○ Colitis
- ○ Joint Pain/Stiffness
- ○ Walking Problems
- ○ General Stiffness
- ○ Difficult Chewing/Clicking Jaw

Gastro-Intestinal

- ○ Excessive thirst
- ○ Frequent Nausea
- ○ Poor/Excessive Appetite
- ○ Vomiting
- ○ Diarrhea
- ○ <1 Bowel Movement Per Day
- ○ Hemorrhoids
- ○ Liver Problems
- ○ Gall Bladder Problems
- ○ Weight Trouble
- ○ Abdominal Cramps

C-V-R

- ○ Chest pain
- ○ Shortness of breath
- ○ Blood pressure Problems
- ○ Varicose Veins
- ○ Ankle Swelling
- ○ Lung Problems/Congestion
- ○ Stroke
- ○ Heart problems
- ○ Irregular Heart Beat

EENT

- ○ Vision Problems
- ○ Dental Problems
- ○ Hearing Difficulty
- ○ Sore Throat
- ○ Ear Aches
- ○ Stuffed Nose

General

- ○ Fatigue
- ○ Allergies
- ○ Loss of Sleep
- ○ Fever
- ○ Headaches
- ○ Skin Issues

Male/Female

- ○ Menstrual Cramping
- ○ Menstrual irregularity
- ○ Prostate/Sexual Dysfunction
- ○ Breast Pain/Lumps
- ○ Vaginal Pain/Infections

Genito-Urinary

- ○ Bladder Trouble
- ○ Discoloured Urine
- ○ Painful/Excessive Urination

After reviewing this information, the doctor will take a detailed history with you in person. If it sounds like your concerns are a good fit for our skillset, the doctor will perform a thorough examination. We do not routinely take X-rays; however if during the assessment, the doctor determines that X-rays will be necessary to change curves in your spine, he will take them today and the fee for those films will be *in addition* to your examination visit fee.

We strive to be your family's most valued health professional and first choice in terms of **getting well and staying well.** Thank-you for choosing our office.

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