Welcome to our Chiropractic Clinic:

Patient Information: *Please Print*

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

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

Shoes Size _____ Marital Status _____ Number of Children _____

Occupation _____ Family Doctor _____

Home Address _____ City _____Postal Code _____

Phone *Home* _____*Work* _____ *Cell* _____

Email _____

Other family members under our 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 involves 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? _____

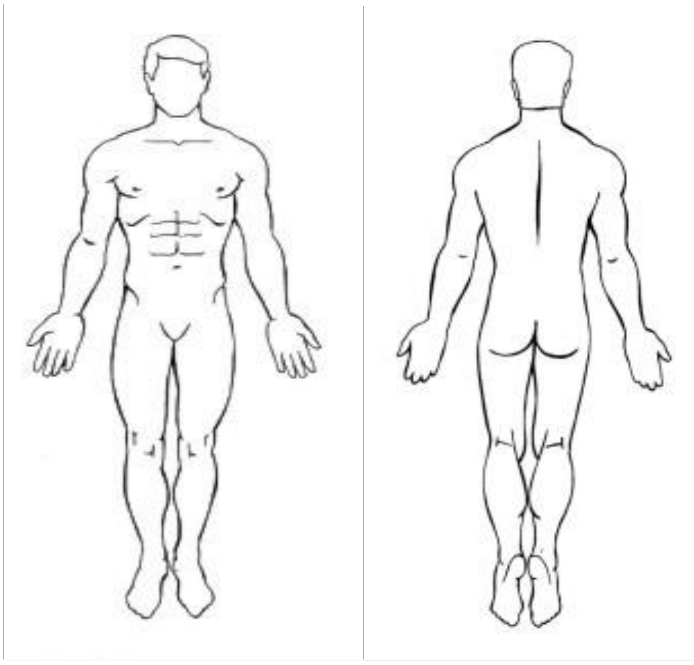
Treatment results? _____

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? M/D/Y _____ / _____ / _____

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 are they? _____

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 _____

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? _____

General Health History

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

Please check ✓ the circles indicating any of the following conditions you have currently Ⓒ or have had in the past Ⓟ or both:

Nervous System

Ⓒ Ⓟ Anxiety	Ⓒ Ⓟ Numbness	Ⓒ Ⓟ Paralysis	Ⓒ Ⓟ Dizziness
Ⓒ Ⓟ Forgetfulness	Ⓒ Ⓟ Cold/Tingling Extremities	Ⓒ Ⓟ Fainting	Ⓒ Ⓟ Seizures
Ⓒ Ⓟ Stress	Ⓒ Ⓟ Balance Problem	Ⓒ Ⓟ Depression	Ⓒ Ⓟ Spasms

Musculo-Skeletal

Ⓒ Ⓟ Low Back Pain	Ⓒ Ⓟ Midback Pain	Ⓒ Ⓟ Neck Pain
Ⓒ Ⓟ Shoulder Pain	Ⓒ Ⓟ Elbow/Wrist Pain	Ⓒ Ⓟ Hip Pain
Ⓒ Ⓟ Knee Pain	Ⓒ Ⓟ Ankle Pain	Ⓒ Ⓟ Night Pain
Ⓒ Ⓟ Clicking Jaw	Ⓒ Ⓟ Walking Problems	Ⓒ Ⓟ General Stiffness

Gastro-Intestinal

Ⓒ Ⓟ Excessive Thirst	Ⓒ Ⓟ Nausea/Vomiting	Ⓒ Ⓟ Poor/Excessive Appetite
Ⓒ Ⓟ Weight Trouble	Ⓒ Ⓟ Diarrhea	Ⓒ Ⓟ <1 Bowel Movement/Day
Ⓒ Ⓟ Heartburn	Ⓒ Ⓟ Liver Problems	Ⓒ Ⓟ Gall Bladder Problems
Ⓒ Ⓟ Abdominal Cramps	Ⓒ Ⓟ Black/Bloody Stool	Ⓒ Ⓟ Gas/Bloating After Meals

Cardiovascular

Ⓒ Ⓟ Chest Pain	Ⓒ Ⓟ Shortness of Breath	Ⓒ Ⓟ Blood Pressure Problems
Ⓒ Ⓟ Varicose Veins	Ⓒ Ⓟ Ankle Swelling	Ⓒ Ⓟ Lung Problems
Ⓒ Ⓟ Stroke	Ⓒ Ⓟ Heart problems	Ⓒ Ⓟ Irregular Heart Beat

EENT

Ⓒ Ⓟ Vision Problems	Ⓒ Ⓟ Sinus Issues	Ⓒ Ⓟ Hearing Difficulty
Ⓒ Ⓟ Sore Throat	Ⓒ Ⓟ Ear Aches	Ⓒ Ⓟ Stuffed Nose

General

Ⓒ Ⓟ Fatigue	Ⓒ Ⓟ Allergies	Ⓒ Ⓟ Sleep Problems
Ⓒ Ⓟ Fever	Ⓒ Ⓟ Headaches	Ⓒ Ⓟ Skin Issues

Male/Female

Ⓒ Ⓟ Menstrual Cramping	Ⓒ Ⓟ Menstrual Irregularity	Ⓒ Ⓟ Prostate Dysfunction
Ⓒ Ⓟ Breast Pain/Lumps	Ⓒ Ⓟ Vaginal Pain/Infections	Ⓒ Ⓟ Sexual Dysfunction

Genito-Urinary

Ⓒ Ⓟ Bladder Trouble	Ⓒ Ⓟ Painful/Excessive Urination	Ⓒ Ⓟ Discoloured Urine

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. If 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.

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