Patient Name:________________________________ **Birth Date (D/M/Y):**________________ **Date:**______________

Occupation/Employer:____ Years at Job:__________

Your Work: ✓ Description: ☐ Labourer ☐ Repetitive Duties ☐ Factory Work ☐ Desk Work ☐ Standing ☐ Shift Work ☐ Driving ☐ Equipment Operator ☐ Heavy Lifting ☐ Moderate Lifting ☐ Light Lifting ☐ Supervisor ☐ Managerial ☐ Homemaker ☐ Technical ☐ Secretarial ☐ Administrative ☐ Professional ☐ Student Other: ____________________

This Portion to be Completed by the Patient or Parent/Guardian Name(s): ____________/____________

I am seeing the chiropractor today for the following reason:______________________________

Other concerns I wish to be addressed:______________________________

Please ✓ the Approriate Responses: ☐ First visit to a chiropractor ☐ Referred by M.D.________________

☐ Have had recent X-Ray of ____________________________ on (date)________________

☐ Have had chiropractic care before (name)____________________________ when?:____________

Current Medication and Condition being Treated: (ie Tylenol® for headaches etc.) ☐ None

1. 2. 3. 4.

5. 6. 7. 8.

General Health:

I consider my weight to be ☐ Normal ☐ Below Average ☐ Above Average ☐ Overweight

I exercise ☐ Regularly ☐ Infrequently ☐ Rarely Sports:________________

Smoking: ☐ No ☐ Yes Number of Cigarettes/Other per day: __________

Alcohol Use: ☐ No ☐ Yes Number of Drinks per day: ________ per week: ________

I have Broken the Following Bones (Please List How and When Injury occurred): ________________

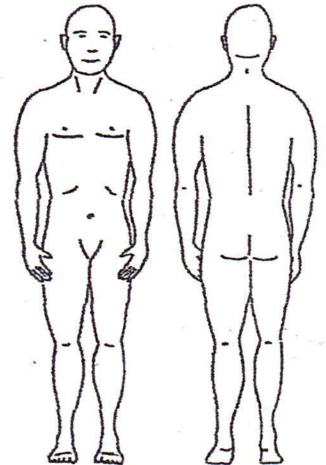
I have had Stitches (Please list Where and When performed): ________________

In the past year I have had: ☐ Blood Tests ☐ Mammogram ☐ Prostate Screen ☐ Chest X-Ray ☐ Bowel Test, please specify: ________________ Other medical tests: ____________

Surgical History: Please ✓ Operations from the list if Surgery Performed: ☐ Wisdom Teeth ☐ Tonsils ☐ Adenoids ☐ Thyroid ☐ Breast ☐ Breast Biopsy ☐ Lymph Node Biopsy ☐ Cardiac Surgery ☐ Open Heart Procedure ☐ Pace Maker ☐ Angiogram ☐ Gall Bladder ☐ Appendix ☐ Bowel ☐ Prostate ☐ Tubal Ligation ☐ Hysterectomy ☐ Caesarean Birth ☐ Hip Replacement ☐ Knee Surgery ☐ Knee Replacement If not listed write any other Surgery(s) in this space: ________________

Please ✓ & Date If You Had the following Health Problems: ☐ aneurysm ________ ☐ stroke(s) ________ ☐ *hepatitis* ________ ☐ *asthma* ________ ☐ *cancer* ________ ☐ *heart condition(s)* ________ ☐ diabetes ________ ☐ epilepsy ________ ☐ respiratory ________ ☐ arthritis ________ ☐ depression ________ ☐ anxiety disorder ________ ☐ hiatus hernia ________ ☐ esophagitis ________ ☐ irritable bowel ________ ☐ ulcer ________ ☐ fibromyalgia ________ ☐ fatigue ________ Other: ________________

Present Complaints:



Family History: Please ✓ the following diseases or illnesses in family background: ☐ diabetes ☐ stroke ☐ cancer ☐ heart attack ☐ anemia ☐ asthma ☐ MS ☐ CF ☐ Alzheimer's ☐ arthritis ☐ osteoporosis ☐ bunions ☐ varicose veins ☐ high blood pressure ☐ Crohn's ☐ diverticulitis ☐ IBS ☐ fibromyalgia ☐ allergies ☐ lactose intolerance ☐ scoliosis ☐ ulcers Other: ________________

How Did Your Problem or Condition begin? ☐ Lifting ☐ Sports ☐ Sprain/Strain ☐ Workplace Associated ☐ Trauma ☐ Slip &/or Fall ☐ Motor Vehicle Accident ☐ Illness ☐ Pregnancy ☐ Gradual Onset ☐ Onset Unknown

Describe Trauma or Accident:________________________________

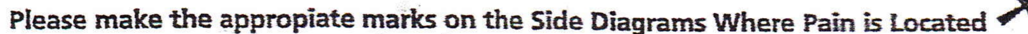
Has it been gradually getting worse? ☐ No ☐ Yes, (describe)________________

Has it been occuring regularly? ☐ No ☐ Yes, (describe)________________

Has it been a problem in the past? ☐ No ☐ Yes, (describe)________________

Current Pain Scale circle level of pain **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)**

Describe Pain (✓ if applicable) ☐ sharp ☐ jabbing ☐ spasms ☐ dull ache ☐ burning ☐ throbbing ☐ pulling



Please make the appropiate marks on the Side Diagrams Where Pain is Located ➚

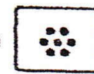
I am filling out this form on behalf of my (please circle) infant / child / minor (Name)____________

Your child's current complaint(s) include the following (please check): ☐Colic ☐Gas ☐Irregular bowel movements ☐Apparent neck discomfort ☐Apparent back discomfort ☐Fever ☐Cough ☐Nasal congestion ☐Excessive regurgitation/spitting up ☐Back arching ☐Disruptive sleep from apparent discomfort ☐Difficulty or delays in crawling ☐Difficullty in walking ☐Problems with the feet or arch ☐Discomfort raising or using the arm or shoulder ☐Won't take a soother ☐Diaper rash ☐Thrush ☐Foul or bad smelling gas or BMs

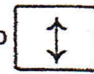
Regarding child or youth complaint(s): ☐Neck pain ☐Back pain ☐Leg pain ☐Difficulty walking / limp ☐Painful use of arm or shoulder ☐Hand or wrist injury ☐Headaches ☐Jaw pain ☐Concussion ☐Abdominal pain ☐Ribcage or chest pain

Has there been any current medical examinations or consultations, testing procedures performed? Please list and date:________________________________

Pain (shade in areas)



Pins & Needles sensation



Pain travels this way

Circle areas of numbness

____

Any other concerns? Please list:________________________________

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☐ **Is your present complaint(s) related to a motor vehicle accident?** ☐No ☐Yes Date that it occurred:__________________ Vehicle collided with:______________________________
Are you planning to claim for your injury through your Insurance Company? ☐No ☐Yes
Do you have extended health benefit coverage? ☐No ☐Yes
Motor Vehicle Accident History (check if applicable): ☐Driver ☐Passenger ☐Front seat ☐Rear seat Wearing a seat belt? ☐Yes ☐No Transported by ambulance? ☐Yes ☐No
Did you have X-rays or other tests performed at the hospital? ☐Yes ☐No
Are you still receiving any ongoing care, physiotherapy, massage because of the MVA? ☐No ☐Yes, describe:____

☐ **Is your present complaint(s) related to a workplace injury that you have reported to WSIB?**☐No ☐Yes, Did it occur more than 2 weeks ago? ☐No ☐Yes Date of accident: ________________ Do you have an active WSIB claim number?_______________
Did you lose time from work? ☐No ☐Yes, Dates of days missed :_______________________
Have your occupational duties changed since the onset of the reported incident and injury?
☐Usual work ☐Modified work ☐Unable to work/Off ☐Changed job ☐Permanent Modified
Regarding your WSIB condition: Has it been getting worse? ☐Yes ☐No ☐Keeps reoccurring

☐ **Is your present complaint(s) related to your pregnancy?** ☐Yes ☐No
If Yes, when is your due date?_____________________ Do you have a Midwife Team or an MD?________________
Have you had an ultrasound or any other special tests?____________
Do you have a history of being anemic? ☐No ☐Yes Have you had iron treatments?☐No ☐Yes, When were you last treated?___________
Regarding previous childbirth(s): ☐Delivery difficulties ☐Prolonged labour #____hours ☐Emergency caesarean ☐Scheduled caesarean ☐Forceps required ☐Further hospitalization required (mother/ infant) Reason:____

Quality of Life Evaluation:

Stress Scale: please circle your current level of stress at this time
(No Stress) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Stress) What is your usual stress level?______
Have you had a history of panic attacks? ☐No ☐Yes When?__________________________
Have you ever been seen in the hospital ER for chest pain? ☐No ☐Yes When?____________
Do you know why you are stressed?____

Generalized Pain Scale: some patients live with pain symptoms on a regular or daily basis, while some experience severe headaches such as migraines that debilitate them for a day or two a month. Pain may be experienced in a problem region, such as an arthritic knee or hip joint, but may also be generalized, such as in abdominal pain that comes and goes.
Please circle your usual level of pain your generally live with
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain) in general, and at its worst:___How long have you been experiencing this for?______ weeks/months/years. What diagnostic testing (MRI, X-rays, ultrasound testing, orthopaedic scopes, CAT scans, etc) have you had done? (Please circle, and list year done:___________________)

Fatigue Scale: is used to look at your fatigue level in general, but also when your fatigue is at its worst. For example, a person may awaken each day extremely fatigued i.e. 8/10 , but get better as the day goes on i.e. 4/10, where the 4/10 would be called their 'usual' fatigue that they essentially live with on a daily basis. It is important to note how long this pattern has been going on for as well. For example, a person may have experienced a 4/10 for fatigue for years, but recently noted that the morning fatigue has gotten worse, now at an 8/10 for 2-3 months.
(No Fatigue) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Fatigue) in general, and at its worst:____

Sleep Problem Scale: sleep quality influences our general health and how we recover from illness and injuries. It is influenced by our sleep environment, as well as underlying conditions.
(No Problem, wake up refreshed) 0 1 2 3 4 5 6 7 8 9 10 (Exhausted, very poor sleep)
How long have you been experiencing this? ______ weeks months years Have you ever had a sleep study? ☐No ☐Yes Do you use a CPAP unit? ☐No ☐Yes ☐Have one but don't use it

Chronic Conditions: do you experience pain regularly (please circle appropriate areas/responses) in your: **Knees** (such as stiffness in bending down and getting up from a squat, kneeling, had X-rays, had MRI, had ultrasound) **Head** (such as migraine, concussion, sinus, dental, TMJ, tinnitus, had MRI, CT)
Hips (such as trying to lay on a particular side, or putting shoes on, or crossing your legs)
Feet or foot (painful heel, arch, or ankle joint, problems walking or standing or running)
Legs (swelling in legs is noted, colouring changes, puffiness in a foot or feet)
Abdomen (sore or painful to press on, bloating and swelling, cramping, diarrhea, constipation problems, had ultrasound, had colonoscopic examination, had X-rays) When?_______________
Have you had an endoscopic examination? ☐No ☐Yes When?__________