



Patient Information

Surname: _____ Given Name: _____ Birthdate: ___/___/___
 Gender: Female / Male Marital Status (please check one): S M D Common-Law
 Address: _____ Apt. No. _____
 City: _____ Province: _____ Postal Code: _____
 Home # (_____) _____ Cell # (_____) _____ Work (_____) _____
 E-mail: _____
 Occupation, Employer's Name, Work Address _____

Medical Doctor Name, Address, Telephone # _____

What is the primary reason for consulting the Spadina Chiropractic Centre? _____

Who may we thank for referring you to the Spadina Chiropractic Centre? _____

Health Profile

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us profiles of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Childhood (to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Y	N		Y	N
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls?	<input type="checkbox"/>	<input type="checkbox"/>	Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>
Did you fall/jump from a height over three feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas? (Physical or Emotional)	<input type="checkbox"/>	<input type="checkbox"/>
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>
Did you take / use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>			

COMMENTS

Adult (18 to Present)

	Y	N		Y	N
Do / did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do / did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do / did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do / did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	Describe your stress level: (1 = None / 10 = Extreme)		
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Occupational: _____	Personal: _____	

On a scale of Poor (P), Good (G), Excellent (E) describe your:

Diet _____ • Exercise _____ • Sleep _____ • General Health _____

Primary Concerns

Briefly describe the chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it...

Sharp Dull Comes and goes Travels Constant

Since the problem started, it is... About the same Getting better Getting worse

What makes it worse? _____

It interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem

- Chiropractor _____
- Medical Doctor _____
- Other _____

Please check () all symptoms you have ever had, even if they do not seem related to your current problem and (x) on those that are current symptoms.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and Needles (legs) | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Pins and Needles (arms) | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness (fingers) | <input type="checkbox"/> Numbness (toes) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |

Current Medications: _____

Consumed vitamins or supplements: Y N

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about:

Children _____

Spouse _____

Mother or Father _____

Brother/Sister _____

Other _____

Have you ever:

Bought bottled water: Y N • Belonged to a health club: Y N

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Signature

Date

DR. EVA CHAN, B.P.H.E., M.Sc., D.C.
DR. BETH CROZSMAN, B.Sc., D.C.