spadinachiropracticcentre
wellness and lifestyle

Welcome To Our Office

Outline of procedures for potential practice members:

Step 1: All new patients are requested to thoroughly complete a confidential "Health History + Lifestyle Record"

Step 2: Your first consultation with the doctor to discuss your concerns and interests.

Step 3: You will receive a "Comprehensive Examination" to determine if chiropractic care is appropriate for your condition. This is an in-depth, advanced assessment of your nervous system to determine how well your brain is communicating with your body. Any interference to this communication may be measured by the following tests: spinal function, Range of Motion, Postural Assessment, Muscle Testing, Advanced Nerve Testing, Bilateral Weight Scales and Balance. As well, if indicated, x-rays will be ordered to visualize the location of spinal damage or problems.

Step 4: You will be advised as to a time you can return for your "Report of Findings" when your doctor will inform you as to your examination results and whether or not your case has been accepted. If accepted, your recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

Step 5: Chiropractic care will begin after your Report of Findings and continue as scheduled until your condition has been fully corrected, or until maximum possible improvement has been obtained.

To save time and allow us to better serve you, please complete all questions on the next 3 pages.

Thank you!

DR. EVA CHAN, M.Sc., D.C.
DR. JOSHUA GELBER, B.Sc., D.C.

Spadina Chiropractic Centre – 200-738 Spadina Avenue, Toronto, Ontario M5S 2J8

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Patient Information

Surname: _____ Given Name: _____

Birthdate: _____ (D) _____ (M) _____ (Y) / Gender: F □ M □ / Marital Status: S □ M □ D □ Common-Law □

Address: _____ Apt. No. _____

City: _____ Province: _____ Postal Code: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

E-mail: _____

Disclaimer: The Spadina Chiropractic Centre is the only party using this email address for the purposes of communicating with you for appointments, statements and invoices, calendars, and monthly newsletters. This email address will not be sold, shared, or entered in unsecure databases.

Occupation, Employer's Name, Work Address (Describe general work duties, I.E.: sitting, standing, physical labour, repetitive motions, driving, etc.)

_____

Medical Doctor Name, Address, Telephone # (if you currently have one)

_____

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?	□	□	Was there any prolonged use of medicine such as antibiotics or an inhaler?	□	□
Did you have any falls?	□	□			
Did you fall/jump from a height over three feet? (I.E. crib, bunk bed, trees)	□	□	Did you play youth sports?	□	□
Were you involved in any car accidents as a child?	□	□	Did you suffer any other traumas? (Physical or Emotional)	□	□
Did you take / use any drugs?	□	□	Were you vaccinated?	□	□
Did you have any surgery?	□	□	As a child, were you under regular chiropractic care?	□	□

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Adult (18 to Present)

	Y	N		Y	N
Have you been in any accidents?	☐	☐	Do / did you participate in extreme sports?	☐	☐
Have you had any surgery?	☐	☐	Do / did you play any adult sports?	☐	☐

Do you have a regular exercise program? ☐ ☐
If yes, how often to do exercise?
☐ 1-2 times per week
☐ 2-4 times per week
☐ 4+ times per week

Describe your stress level: (1 = none / 10 = extreme)
Occupational: _____ Personal: _____

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

Current Health
Main/Current Health Concern(s): _____

When did this begin? _____ **Has it occurred before?** ☐ Y ☐ N

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

If you are experiencing pain, is it…
☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles/Numb ☐ Constant ☐ Intermittent ☐ Burning

Place an X on the scale to indicate the severity of your discomfort (if applicable):
Least 1 2 3 4 5 6 7 8 9 10 *Worst*

What makes it worse?
☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Lying Down ☐ Cold ☐ Dampness
☐ Other: _____

What makes it better?
☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication ☐ Chiropractic ☐ Supplements
☐ Other: _____

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.

Nervous System
☐ Nervousness
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Convulsions
☐ Fainting
☐ Cold/Tingling Extremities
☐ Stress

Musculo-Skeletal
☐ Low Back Pain
☐ Pain Between Shoulders
☐ Heartburn
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficulty Chewing/Clicking Jaw
☐ General Stiffness

Gastro-Intestinal
☐ Black/Bloody Stool
☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ Hemorrhoids
☐ Liver Problems ☐ Colitis
☐ Gall Bladder Problems
☐ Abdominal Cramps
☐ Gas/Bloating after meals

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Genito-Urinary
- □ Bladder Trouble
- □ Painful/Excessive Urination
- □ Discolored Urine

C-V-R
- □ Chest Pain □ Short Breath
- □ Blood Pressure Problems
- □ Irregular Heartbeat
- □ Heart Problems □ Varicose Veins
- □ Lung Problems/Congestion
- □ Ankle Swelling □ Stroke

EENT
- □ Vision Problems □ Sore Throat
- □ Ear Aches □ Hearing Difficulty
- □ Stuffed Nose

Intake
- □ Coffee □ Tea
- □ Alcohol □ Cigarettes
- □ White Sugar

Sleeping Position
□ Back □ Side □ Stomach
Type of Mattress: _____
Age of Mattress: _____

Is it comfortable? □ Y □ N
Type of Pillow: _____
Age of Pillow: _____
Does it support your neck? □ Y □ N

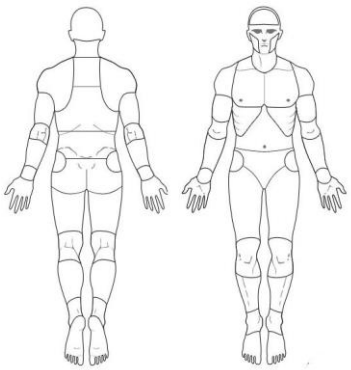
General
- □ Fatigue □ Allergies
- □ Loss of Sleep
- □ Fever □ Headaches

Male/Female
- □ Menstrual Irregularity
- □ Menstrual Cramping
- □ Vaginal Pain Infections
- □ Breast Pain/Lumps
- □ Prostate/Sexual Dysfunction

Female
When was your last period?
_____
Are you pregnant?
□ Y □ N □ Unsure

Check any of the following diseases you have had:
- □ Pneumonia □ Influenza
- □ Chicken Pox □ Arthritis
- □ Diabetes □ Epilepsy
- □ Cancer □ Measles
- □ Mental Disorder □ Thyroid
- □ Heart Disease □ Eczema
- □ Psoriasis

Please outline on the diagram the area of your discomfort and any radiation of pain.



Current Medications: _____

Current vitamins or supplements: _____

Do you currently wear custom orthotics/shoe inserts? _____

Have you had x-rays taken in the last six months? □ Y □ N
If Yes, at what facility? Of what? _____

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 your:

Spouse _____

Children _____

Number of Children: _____ Names & Ages: _____

Mother/Father _____

Brother/Sister _____

Other _____

Has anyone in your family ever had a spinal check-up? □ Y □ N
If Yes, at what facility? _____

On a scale of 1 to 10, 10 being the highest, rate your commitment to improve your health: _____

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Why Chiropractic Care?
People go to a chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (**Preventative Care**). These are the three types/phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three types/phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

□ **Preventative Care** – Life Enhancement and Wellness Care
□ **Corrective Care** – Removing Cause and Remodeling Soft Tissue
□ **Relief Care** – Band-Aid Care only
□ *Check here if you want the doctor to select the type of care appropriate for your condition.*

Please read carefully:
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company.

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

In order for the Doctor at the Spadina Chiropractic Centre to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiograph examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by him or her or any party authorized to do so by them.

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. The Spadina Chiropractic Centre has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Our only practice objective is to eliminate a major interference to the expression of the body's internal power. Our method is specific adjusting to correct vertebral subluxations.

I, _____ have read and understand the subluxation pamphlet.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept the potential for chiropractic care on this basis.

_____ _____
Patient Signature/Guardian's Consent Date

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