



# ACTIVE FAMILY CHIROPRACTIC & WELLNESS CENTRE

80 QUEEN ST. S MISSISSAUGA, ONTARIO L5M 1K4 (905) 804-8657

## CONFIDENTIAL PATIENT INFORMATION

Today's Date (D, M, Y): \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name: (PLEASE PRINT) \_\_\_\_\_

First Name: (PLEASE PRINT) \_\_\_\_\_ Middle Initial: \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_

Phone: Home: (\_\_\_\_) \_\_\_\_\_ Business: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Circle the following: Male / Female Married / Single

Date of Birth (D,M,Y): \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Spouse's Name (if applicable): \_\_\_\_\_

Do you have children? Yes o No o Names/Ages? \_\_\_\_\_

Occupation: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Extended Health Insurance Coverage: Yes o No o If yes, amount eligible from insurance: \$ \_\_\_\_\_

Please describe your physical complaint(s):

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How did you hear about our office? Please circle one (Family, Friend, Doctor, Sign, Internet)

Name of referral source:

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**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

PLEASE CONTINUE TO NEXT PAGE →

**HEALTH INFORMATION**

Have you been to another Chiropractor? Yes o No o

If YES, Chiropractor's Name: \_\_\_\_\_

When: \_\_\_\_\_

Have you had spinal x-rays in the last 12 months? Yes o No o

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Number of Hours at Work per week? Hours/Week \_\_\_\_\_

Hours of Sleep per Night? (Circle) 0-4 4-6 6-8 8-10 10+

Rate Appetite: (Circle) Poor Medium Excellent

(Please Check Yes or No)

Yes No

- 1. Do you consume alcohol?  Yes  No
- 2. Do you exercise?  Yes  No If yes, what kind of exercise & how often?  
\_\_\_\_\_
- 3. Have you had any surgery?  Yes  No If yes, what kind & when?  
\_\_\_\_\_
- 4. Have you been hospitalized?  Yes  No If yes, what for & when?  
\_\_\_\_\_
- 5. Do you have a family history of cancer, diabetes, or heart disease?  Yes  No If yes, who & what condition?  
\_\_\_\_\_
- 6. Do you have a history of high cholesterol, high blood pressure or aneurysm?  Yes  No If yes, which & when?  
\_\_\_\_\_

**PATIENT'S NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

PLEASE CONTINUE TO NEXT PAGE →

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.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Smallpox        | <input type="checkbox"/> Pleurisy             | <input type="checkbox"/> Eczema                  |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Chicken pox     | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Osteoporosis            |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Mental Health Disorders |
| <input type="checkbox"/> Whooping cough  | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Polio                |  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart disease   | <input type="checkbox"/> Low back pain        |  |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Osteoarthritis       |  |
| <input type="checkbox"/> Mumps           | <input type="checkbox"/> Influenza       | <input type="checkbox"/> Psoriasis            |  |

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD WITHIN THE LAST SIX MONTHS**

**MUSCULOSKELETAL**

- Low back pain
- Hip or leg pain
- Upper back pain
- Shoulder pain
- Neck pain
- Arm pain
- Muscle tightness
- Joint/stiffness
- Walking problems
- TMJ (Jaw) problems

**NERVOUS SYSTEM**

- Headache
- Numbness
- Nervousness
- Paralysis
- Weakness
- Dizziness
- Fainting
- Confusion/Depression
- Convulsions
- Cold/Tingling extremities
- Stress

**EENT**

- Eye problems
- Allergies
- Earaches/infections
- Hearing Loss
- Sore throat
- Dental problems
- Stuffed nose
- Sinus problems

**GASTROINTESTINAL**

- Poor/Excessive appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gall bladder problems
- Weight trouble
- Abdominal cramping
- Gas/Bloating after meals
- Heartburn
- Black/Bloody stool
- Colitis
- Colic
- Ulcers

**GENTOURINARY**

- Bladder problems
- Painful/Excessive urination
- Discoloured urine
- Prostate problems
- Sexual dysfunction
- Kidney problems
- Other: \_\_\_\_\_

**GENERAL**

- Difficulty sleeping
- Fatigue
- Fever

**CARDIORESPIRATORY**

- Chest pain
- Blood pressure
- Irregular heartbeat
- Heart disease
- Varicose veins
- Stroke
- Ankle swelling
- Shortness of breath
- Lung problems
- Asthma
- Smoker /  Non-Smoker

**GYNECOLOGIC**

- Menstrual problems
- Vaginal pain/infection
- Breast pain/lumps
- Endometriosis/Fibroid
- Ovarian cyst

*Date of last period:*  
(D/M/Y) \_\_\_\_\_

*Are you pregnant?*

- Yes
- No
- Not sure
- Hysterectomy

**PATIENT'S NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

PLEASE CONTINUE TO NEXT PAGE →

Tell us more about your visit:

Reason for attending office: \_\_\_\_\_

Where is your pain LOCATED? CIRCLE THE LOCATION(S) ON THE DIAGRAM AT THE BOTTOM

How LONG have you had this condition?  Days \_\_\_\_  Weeks \_\_\_\_  Years \_\_\_\_

Have you had this (or similar) condition IN THE PAST?  Yes, when: \_\_\_\_\_  No

How would you DESCRIBE your pain?

Dull  Sharp  Throbbing  Stabbing  Other \_\_\_\_\_

Does the pain TRAVEL anywhere else?

Arms and fingers  Legs and toes  Head  Other \_\_\_\_\_

What AGGRAVATES your pain? \_\_\_\_\_

What RELIEVES your pain? \_\_\_\_\_

Is your condition GETTING WORSE?  Yes  No  Constant  Comes and goes

Is this interfering with your:  Work  Sleep  Daily Routine  Sport  Other \_\_\_\_\_

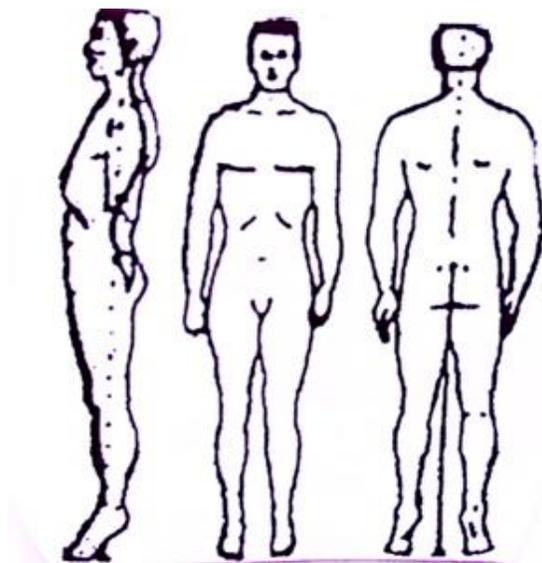
What other treatments have you tried? \_\_\_\_\_

What medications are you currently taking?

None  Pain Killers  Anti-inflammatory  Others: \_\_\_\_\_

Please check off any that you've experienced in the past:

	<b>Please explain (i.e., when, what happened, etc.)</b>
<input type="checkbox"/> Car accidents	
<input type="checkbox"/> Work injuries	
<input type="checkbox"/> Sports/Recreational injuries	
<input type="checkbox"/> Home injuries	
<input type="checkbox"/> Birth/Child complications	
<input type="checkbox"/> Other	



VCTE

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_