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: (print)_____ First Name: (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 / No If yes, amount eligible from insurance: $_____
Please describe your physical complaint(s): _____
_____
How did you hear about our office? Please circle one (Family, Friend, Doctor, Sign, Internet):
Name of referral Source: _____

HEALTH INFORMATION

Have you been to another Chiropractor? Yes/No
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?	☐	☐	
2. Do you exercise?	☐	☐	If yes, what kind of exercise & how often? _____
3. Have you had any surgery?	☐	☐	If yes, what kind & when? _____
4. Have you been hospitalized?	☐	☐	If yes, what for & when? _____
5. Do you have a family history of cancer, diabetes or heart disease?	☐	☐	If yes, who & what condition? _____
6. Do you have a history of High cholesterol, high blood pressure or aneurysm.	☐	☐	If yes, which & when? _____

PATIENT'S SIGNATURE:_____ 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:

☐ Pneumonia
☐ Whooping cough
☐ Small pox
☐ Heart disease
☐ Rheumatoid arthritis
☐ Osteoarthritis
☐ Rheumatic fever
☐ Anemia
☐ Chicken pox
☐ Thyroid disease
☐ Epilepsy
☐ Psoriasis
☐ Polio
☐ Measles
☐ Diabetes
☐ Influenza
☐ Mental disorders
☐ Eczema
☐ Tuberculosis
☐ Mumps
☐ Cancer
☐ Pleurisy
☐ Low back pain
☐ Osteoporosis

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 pain/stiffness
☐ Walking problems
☐ TMJ (Jaw) problems

NERVOUS SYSTEM
☐ Headache
☐ Numbness
☐ Nervousness
☐ Paralysis
☐ Weakness
☐ Dizziness
☐ Fainting
☐ Forgetfulness
☐ Confusion/depression
☐ Convulsions
☐ Cold/tingling extremities
☐ Stress

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

EENT
☐ Eye problems
☐ Allergies
☐ Ear aches/infection
☐ 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

GENERAL
☐ Difficulty sleeping
☐ Fatigue
☐ Fever

GENITOURINARY
☐ Bladder problems
☐ Painful / excessive urination
☐ Discoloured urine
☐ Prostate problems
☐ Sexual dysfunction
☐ Kidney stones
☐ Other_____

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

Date of last period:
(D,M,Y)_____

Are you pregnant?
☐ Yes ☐ Not sure
☐ No ☐ 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) conditions 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

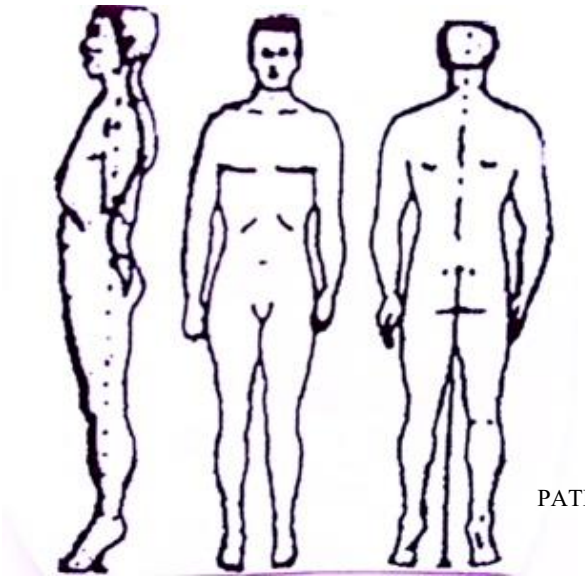
Is this interfering with your: □ Work □ Sleep □ Daily Routine □ Sport □ Other_____

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:

	Please explain (ie. when, what happened, etc.)
□ Car Accidents	
□ Work injuries	
□ Sports/Recreational injuries	
□ Home injuries	
□ Birth/Child complications	
□ Other	



VCTE □

DOCTOR'S NOTES: □ L □ P □ Dx

PATIENT'S NAME: _____

DATE:_____

Dr. Ongko / Dr. Pacis