

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? 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 SIGNATURE: _____ DATE: _____

PLEASE CONTINUE 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"/> Rheumatic fever | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Small pox | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental disorders | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Eczema | <input type="checkbox"/> 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

CARDIORESPIRATORY

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

NERVOUS SYSTEM

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

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 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? _____

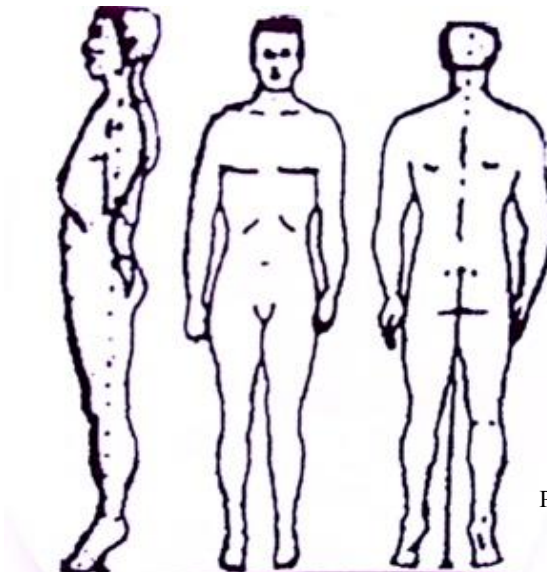
What medications are you currently taking?
 None Pain Killers Anti-inflammatory Others: _____

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

	Please explain (ie. when, what happened, etc.)
<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

DOCTOR'S NOTES: L P Dx



PATIENT'S NAME: _____

PLEASE CONTINUE TO NEXT PAGE →

CLINIC FEE SCHEDULE

Chiropractic

Regular Fee

Initial Examination	70.00
Adjustment	46.00
Spinal Decompression	100.00
Re-Examination	50.00
Progress Exam	20.00
Spinal Care Class	40.00

Children

Adjustment	34.00
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(12 and under and parents are active patients of the office)

X-Rays

Full spine x-rays	90.00
Sectional x-rays	36.00

Other Services Offered:

Registered Massage Therapy, Foot Care (Chiropody) and Custom Foot Orthotics

PATIENT'S NAME: _____

Date: _____

PLEASE CONTINUE NEXT PAGE →