66 Baldwin Street, Suite 200
Brooklin, ON
L1M-1A3
(905) 425 7000

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

AGE: _____ D.O.B _____

ADDRESS: _____ CITY: _____ POSTAL CODE_____

HOME PHONE: _____ WORK\CELL PHONE: _____

MAY WE LEAVE YOU A MESSAGE? IF SO, WHERE? Home / Work / Cell / None

EMAIL: _____

SEX: M / F MARTIAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED /SEPARATED

OCCUPATION: _____ EMPLOYER: _____

SPOUSE'S NAME: _____ OCCUPATION:_____

DO YOU HAVE CHILDREN? YES / NO IF YES, WHAT AGE(S)? _____

FAMILY PHYSICIAN: _____ CITY:_____ PHONE:_____

REFERRALS ARE OUR HIGHEST COMPLIMENT. PLEASE SHARE HOW YOU HEARD AOUT US?

___ Flyer ___ One of your patients (who? _____)

___Newspaper ___ Referral from doctor (which doctor? _____)

___Website ___ Facebook

___Sign ___Yellow Pages

___ Other (Please explain: _____)

PATIENT CONDITION

REASONS/COMPLAINTS FOR SEEKING CHIROPRACTIC/MASSAGE/LASER CARE:

PRIMARY REASON: _____

OTHER REASONS: _____

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? Yes / No Who? _____

CITY? _____ DATE OF LAST VISIT? _____

FOR WHAT COMPLAINT(S)? _____

COMPLAINT RESOLVED? Yes / No / Somewhat

HAVE YOU HAD XRAYS TAKEN IN THE PAST 5 YEARS? YES / NO IF SO, WHAT AREA(S)?

_____

HAVE YOU BEEN TO ANY OTHER HEALTHCARE PRACTITIONER FOR YOUR CURRENT COMPLAINT?
YES / NO WHO? _____ PROFESSION? _____

WHEN DID THIS CONDITION BEGIN? _____ OCCURRED BEFORE? Yes / No

WHAT AGGRAVATES YOUR CONDITION(S)?

__Sitting __Walking
__ Standing __Sleeping
__Bending __Weather
__Lifting ___Other (Please explain:_____)

WHAT RELIEVES YOUR CONDITION(S)?

__Ice __Bed Rest
__Heat __Walking
__Massage __Medications (Which? _____)
__Stretches & exercise __Other (Please explain:_____)

IS IT GETTING: Better / Worse / Constant / Comes and goes

IS THE PAIN: Sharp __ Shooting __ Dull __ Burning __ Numb __ Throbbing __ Tingling __ Stiff __ Aching__
Other (Please explain: _____)

ON A SCALE OF 1-10 PLEASE CIRCLE THE SEVERITY OF YOUR PAIN:

No Pain < 0 1 2 3 4 5 6 7 8 9 10 > Severe Pain

HEALTH INFORMATION

HEIGHT: _____ WEIGHT:_____

BLOOD PRESSURE (High or Low?) _____

DO YOU CURRENTLY SUFFER FROM ANY DIAGNOSED MEDICAL CONDITIONS? Yes / No

ARE YOU CURRENTLY ON ANY MEDICATIONS? Yes / No IF YES, WHICH ONE(S)?

_____

ARE YOU CURRENTLY PREGNANT? Yes / No IF YES DUE DATE :_____

ARE YOU A SMOKER? Yes / No HOW MANY YEARS? _____ # OF CIGARETTES/DAY? _____

DO YOU CONSUME ALCOHOL? Yes / No # OF DRINKS PER WEEK? _____

DO YOU CONSUME ANY OTHER SUBSTANCES? IF YES, WHICH?

_____

HAVE YOU HAD ANY SURGERY? IF YES, WHAT KIND AND WHEN?

_____

DO YOU HAVE ANY HARDWARE (PINS/PLATES/SCREWS? Yes / No

IF SO, WHERE?

_____

PLEASE LIST ALL MEDICAL CONDITIONS THAT APPEAR IN YOUR FAMILY HISTORY AND IN WHOM:

_____

_____

_____

PLEASE CHECKMARK CONDITIONS THAT YOU HAVE/HAVE HAD

Musculoskeletal
___Low back pain
___Pain between shoulders
___Neck pain
___Headaches
___Arm pain
___Leg pain
___Joint pain/stiffness
___Swelling
___Jaw pain/clicking
___Arthritis
___Osteoporosis

N**ervous system**
___Numbness in arm/hand
___Numbness in leg/foot
___Paralysis
___Dizziness
___Forgetfulness
___Anxiety
___Depression
___Fainting
___Convulsions
___Epilepsy

Male / Female Reproductive
___Prostate problems
___Menstrual pain/cramps
___PMS
___Menstrual cycle irregularity
___Endometriosis
___Back pain with menstrual.cycle

Cardiovascular / Respiratory
___Cold hands/feet
___Bruise easily
___Blood disorder
___Chest pain
___Shortness of breath
___High blood pressure
___Irregular heartbeat
___Heart problems
___Pneumonia
___Bronchitis
___Asthma
___Stroke

Eyes / Ears / Nose / Throat
___Vision problems
___Loss of smell
___Dental problems
___Sore throat
___Earache/ infection
___Hearing loss
___Ringing in ears
___Sinus congestion

___Menopause
___Breast pain / lumps
___Fibroids / cysts
___Infertility
___Miscarriage
___Difficult delivery of baby

Gastro-Intestinal
___Poor appetite
___Excessive thirst
___Frequent nausea
___Diarrhea
___Constipation
___Bloating/Gas
___Abdominal cramps
___Heartburn
___Liver problems
___Bladder problems
___Kidney problems
___Painful/excess urination

General
___Fatigue
___Irritability
___Allergies
___Poor sleep
___Poor balance
___Poor concentration
___High stress
___Weight loss
___Weight gain
___Fever
___Frequent colds

Other
_____
_____
_____
_____

I HERBY CERTIFY THAT THE STATEMENTS AND ANSWERS GIVEN ON THIS FORM ARE ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THE PRACTITIONERS OF ANY CHANGES IN MY HEALTH. I AGREE TO ALLOW KNOTS 'N' JOINTS WELLNESS CLINIC TO ASSESS ME FOR FURTHER EXAMINATION.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

PRACTIONER'S SIGNATURE: _____

DATE: _____