197 County Court Blvd, Suite 204; Brampton, Ont; L6W 4P7

CONFIDENTIAL PATIENT HEALTH QUESTIONNAIRE

Welcome to our office. Please fill out the following questionnaire to the best of your ability to help the Doctor provide you with the best care possible. If you have any questions, or need help filling out the form please let us know. If under the age of 12, please fill out the pediatric intake form and provide guardian signature.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City *Province* *Postal Code*

Home Phone: _____ Work: _____ Cell: _____

E-Mail: _____ Occupation: _____ Gender: M F

Spouse/Partner: _____ Children: ( ) _____

Emergency Contact: _____ Relation: _____Phone: _____

How did you hear about us? _____

Is it okay to use your email to send appointment reminders/office emails? □ Yes □ No

What is the nature of this visit? □ **Health Optimization** □ **Complaint** □ **Injury** □ **Other**

HEALTH INFORMATION:

Medical Doctor: _____ Phone: _____

Last Physical Exam: _____ Have you had any **spinal x-rays**? □ Yes □ No

Please list any health conditions you have been treated for in the last year?

_____

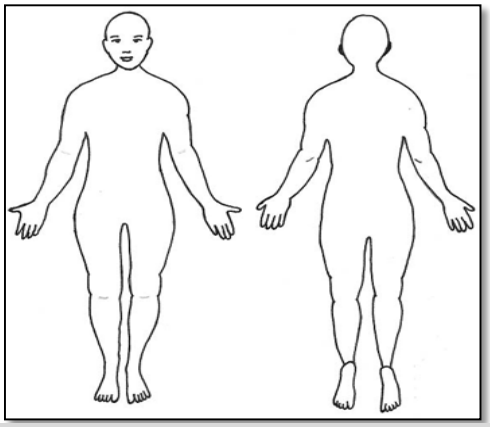
Have you had **previous chiropractic care**? □ Yes □ No If yes, have you been adjusted? □ Yes □ No

What was the reason for your visit? _____ Date of last chiropractic visit? _____

COMPLAINT DIAGRAM:

Please code areas of discomfort. Add any addition information, or sensations

Sharp xxx
Tingling/Numbness ///
Burning +++
Deep/Achy/Dull ooo
Tightness TTT
Other: _____



Please indicate your present level of **discomfort**: (circle)

0 (none) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please indicate where you believe you fall in terms of your **health**: (circle)

Poor →Challenged →Good → Excellent

PATIENT SYMPTOMS:

What is your **chief complaint**? _____

When did it start? _____

The complaint is getting: □ *WORSE* □ *BETTER* □ *SAME*

The complaint started: □ SUDDENLY □ GRADUALLY

What may have caused the problem? _____

Duration of symptoms: □ CONSTANT □ HOURLY □ DAILY □ ON & OFF □ INFREQUENT

Has the complaint affected your **daily activities**? □ Yes □ No How? _____

Has the complaint affected your **ability to sleep**? □ Yes □ No How? _____

Has the complaint affected your **appetite**? □ Yes □ No How? _____

Has this happened before? □ Yes □ No If so, when? _____

Have you had to miss **work**? □ Yes □ No Last day of work:_____
Is the complaint worse at a certain time of day? □ Yes □ No What time? _____
Does the **weather** affect your complaint? □ Yes □ No How? _____
What ***Aggravates*** your complaint? _____ What ***Relieves*** *it?* _____

MEDICAL HISTORY:
Please list all **medications** you are taking (including over the counter medication like Tylenol, or Advil):
_____
Please list any **hospitalizations** or **surgeries** (include year):
_____
Please list any **supplements** that you are on (include brand if known):
_____
When was the last time you were on **antibiotics**? _____
Do you get a cold or respiratory illness often? □ Yes □ No
Do you smoke? □ Yes □ No How many packs/week? _____
Do you drink alcohol? □ Yes □ No How many drinks/week? _____

Do you have a bleeding disorder? *Yes* *No*
Do you have a heart condition? *Yes* *No*
Do you have a pacemaker? *Yes* *No*
Do you have any allergies? *Yes* *No* *If yes, to what?* _____

FEMALE ONLY:
Are you pregnant? □ Yes □No □ Not sure If yes, how may weeks? _____
Are you breastfeeding? □ Yes □ No
Are you presently trying to conceive? □ Yes □ No
Are you taking birth control? □ Yes □ No Reason: _____
What was the 1st day of your last period? _____ Average length of your cycle: _____ days
Do you have irregular or painful periods? □ Yes □ No
Any pelvic conditions/surgeries (such as PCOS, endometriosis, fibroids, hysterectomy): _____
Are you on HRT? □ Yes □ No

What level of **STRESS** are you experiencing: None 1 2 3 4 5 Severe
How well do you cope with stress: □ Poorly □ Ok □ Well
What is your **energy level**: □ Exhausted □ Low □ Good □ Excellent
How often do you **exercise**? □ Daily □ 3-5 days/week □ 1-2 days/week □ Infrequent
Do you eat fresh organic/pesticide free produce daily? □ Yes □ No
Do you have any sort of special diet or lifestyle? (i.e. gluten free, Paleo, dairy free, vegan, etc.)
Explain;_____

FAMILY HISTORY:	Heart Disease	Diabetes	Arthritis	Cancer	Other: ____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow the doctor to examine me for further evaluation, which may include X-Rays and/or thermal and EMG analysis.

Patient/Parents Signature_____**Date**_____

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DETAILED REVIEW OF SYSTEMS √ Present x Past

Cardiovascular □ N/A □ Poor Circulation □ High Blood Pressure □ Aortic Aneurysm □ Heart Attack □ Chest Pain □ High Cholesterol □ Pacemaker □ Jaw Pain □ Irregular Heartbeat □ Swelling of Legs □ Stroke	Allergy/Immunological □ N/A □ Autoimmune Disorder □ Chronic Allergies □ Seasonal Allergies □ Food Allergies □ Environmental Allergies □ Allergy Shot □ Cortisone USe □ HIV/AIDS □ Hives □ Weak Immune System	□ Parkinsons Disease □ Carpal Tunnel □ Balance/Coordination Issues □ ADHD/ADD/Sensory Processing Disorder (PSD) □ Autism/Spectrum Disorder □ Migraines/Headaches □ Bell's Palsy □ Poor Fine/Gross Motor Skills □ Epilepsy □ Inflammation □ Trigeminal Neuralgia □ Brachial Plexus Injury □ Auditory Processing Issues □ Toe Walking □ Vertigo/Dizziness □ Sensory Integration Issues
Ear/Nose/Throat/Eyes □ N/A □ Sinus Congestion □ Sinus Infection □ Nosebleeds □ Sore throat □ Difficulty swallowing □ Earache □ Ear Infections □ Dizziness □ Hearing Loss □ Bleeding Gums □ Glaucoma □ Double Vision □ Blurred Vision □ Red, itchy (Allergy)	Gastrointestinal □ N/A □ Pancreatitis □ Acid Reflux □ Bowel Problems □ Constipation □ Upset Stomach □ Gas Pains □ Ulcers □ Gallbladder Problems □ Liver Problems □ Diarrhea □ Nausea/Vomiting □ Poor Appetite □ Bloody Stools □ Crohn's Disease □ Hiatal Hernia	Constitutional □ N/A □ Weight Loss/gain □ Energy Level (low) □ Energy Level (high) □ Difficulty Sleeping □ Chronic Fatigue □ General Malaise □ Compulsive Behaviour □ Behavioural Issues □ Learning Disabilities □ Speech Delay □ Restless Leg Syndrome □ Obesity
Respiratory □ N/A □ Asthma □ Shortness of Breath □ Upper Resp. Infection □ Cold/Flu □ Pneumonia □ Cough/Wheezing □ Emphysema □ RSV □ Tuberculosis	Musculoskeletal □ N/A □ Chronic Hip Dislocation □ Torticollis □ Poor Posture □ Neck Pain □ Back Pain □ Arthritis □ Rheumatoid Arthritis □ Joint Stiffness □ Muscle Weakness	Psychiatric □ N/A □ Depression □ Anxiety Disorder □ Usual Stress □ OCD □ Bipolar Disorder □ Seasonal Affect Disorder □Social Anxieties □ Memory Loss □ Night terrors
Genitourinary □ N/A □ Kidney Disease □ Lower Side Pain □ Burning Urination □ Blood in Urine □ Kidney Stones □ Bed Wetting/Enuresis □ Prostate Problems □ Rectal Prolapse	Neurological □ N/A □ Tic Disorder □ Seizures □ Head injury/Whiplash □ Brain Aneurysm □ Numbness/tingling □ Pinched Nerves □ Radiating Pain □ Sciatica	Endocrine □ N/A □ Hyperthyrodism/Hypothyrodism □ Diabetes (Type 1/ Type 2) □ Hair loss □ Menopause/Hot Flashes □ Menstrual problems □ Endometriosis □ Polycystic Ovarian Syndrome □ Infertility/Fertility Issues

Patient Name: _____ Date:_____