

# 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 What are their names/ages? \_\_\_\_\_

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

Do you have 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? \_\_\_\_\_

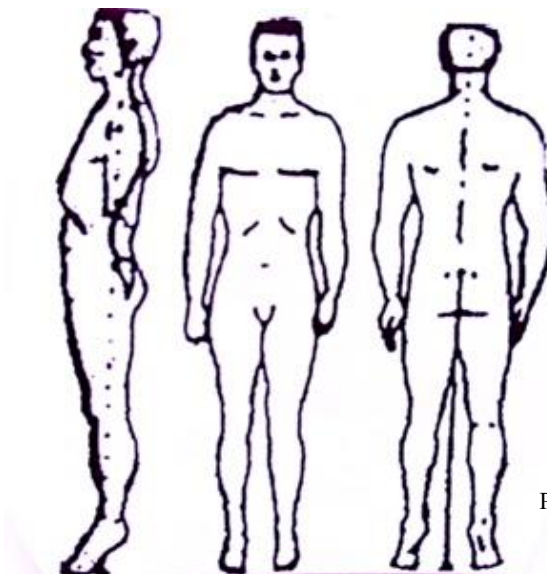
What medications are you currently taking?  
 None     Pain Killers     Anti-inflammatory     Others: \_\_\_\_\_

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

	<b>Please explain (ie. 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**

**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	45.00
Adjustment-Extended	70.00
Spinal Decompression	100.00
Re-Examination	50.00
Progress Exam	20.00
Spinal Care Class	40.00

### **Children**

Adjustment	33.00
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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 →