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: (PLEASE PRINT) _____

First Name: (PLEASE 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 No 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:

_____

PATIENT'S SIGNATURE: _____ DATE: _____

PLEASE CONTINUE TO NEXT PAGE→

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 No

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 NAME: _____ 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
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Whooping cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Smallpox
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart disease
- ☐ Thyroid disease
- ☐ Influenza
- ☐ Pleurisy
- ☐ Rheumatoid arthritis
- ☐ Epilepsy
- ☐ Polio
- ☐ Low back pain
- ☐ Osteoarthritis
- ☐ Psoriasis
- ☐ Eczema
- ☐ Osteoporosis
- ☐ Mental Health Disorders

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

NEROVUS SYSTEM
- ☐ Headache
- ☐ Numbness
- ☐ Nervousness
- ☐ Paralysis
- ☐ Weakness
- ☐ Dizziness
- ☐ Fainting
- ☐ Confusion/Depression
- ☐ Convulsions
- ☐ Cold/Tingling extremities
- ☐ Stress

EENT
- ☐ Eye problems
- ☐ Allergies
- ☐ Earaches/infections
- ☐ 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

GENITOURINARY
- ☐ Bladder problems
- ☐ Painful/Excessive urination
- ☐ Discoloured urine
- ☐ Prostate problems
- ☐ Sexual dysfunction
- ☐ Kidney problems
- ☐ Other: _____

GENERAL
- ☐ Difficulty sleeping
- ☐ Fatigue
- ☐ Fever

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

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

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

Are you pregnant?
- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ 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) condition 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_____

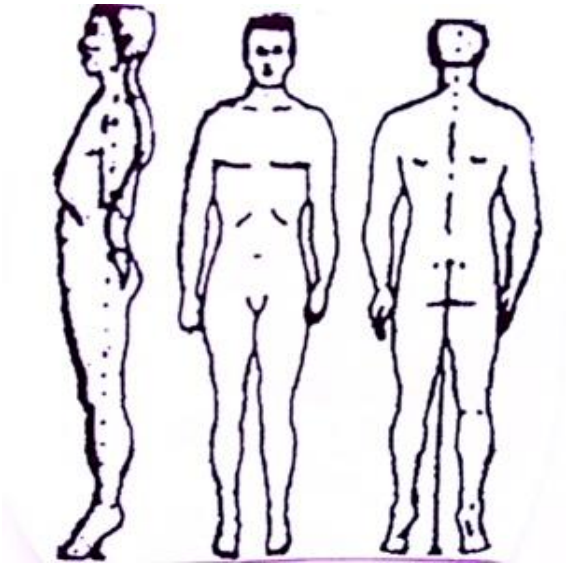
What other treatments have you tried? _____

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 (i.e., when, what happened, etc.)
☐ Car accidents	
☐ Work injuries	
☐ Sports/Recreational injuries	
☐ Home injuries	
☐ Birth/Child complications	
☐ Other	



VCTE ☐

PATIENT'S NAME: _____ **DATE:**_____

Dr. Ongko / Dr. Pacis