*Blackburn Chiropractic Clinic*
*110 Bearbrook Rd # 201, Gloucester ON - K1B5R2*
*(613) 837-6690*

## PERSONAL INFORMATION

Name: ________________________________ Email: __________________________________

Address: _______________________________ City _______ Prov ____ Postal code____________

Home Phone: _____________________________Work: ________________________________

Cell Phone _______________________________

Birth Date (dd/mm/yyyy) _____ / _____ /_____ Age ______ □ Male □ Female

Occupation & Employer ___________________________________________________________

Marital Status □ S □ M □ C/L □ D □ W

⟶Emergency Contact: ______ __________________________ Phone number ________________

Are you a student? □ Yes □ No If yes, where? _____________________________________________

⟶How did you hear about our clinic? □ Personal referral: ___________________ □ Phone Book

□ Internet □ Sign □ Health professional: ___________________ □ Other: ______________________

⟶Have you had any previous chiropractic care? □ Yes □ No If yes, with whom? _____________________

Date of last treatment ________________________ Were you happy with the results? □ Yes □ No

⟶Current Family Physician: _________________________ Phone number ____________________

May we contact your family physician for co-management? □ Yes □ No

## REASON(S) FOR YOUR APPOINTMENT

Is the purpose of this appointment related to: □ Workplace injury □ Auto accident □ Fall / Trauma □ Sports
□ Chronic Discomfort □ Wellness care □ Other _________________________
If job related, are you claiming under WSIB? □ Yes □ No Claim # _______________________

If auto accident, are you claiming under insurance? □ Yes □ No Claim # _______________________

Name: ____________________________________________ Date: ______________________

Briefly describe your main health concern(s): ____________________________________________

____________________________________________________________________________

____________________________________________________________________________

How long have you had this condition? __________________________________________________

Is your condition getting: worse / better / same? (circle one)

What makes the condition worse? ______________________________________________________

What makes the condition better? ______________________________________________________

What have you tried that has not worked? _______________________________________________

Have you seen any other physician or healthcare professional for this complaint? □ Yes □ No

If yes, with whom: ____________________________ Date of last treatment: ____________________

Were x-rays or any other medical testing performed? ________________________________________

____________________________________________________________________________

____________________________________________________________________________

List any treatments performed: _______________________________________________________

____________________________________________________________________________

Mark the areas of your body where you feel the described sensations.

Use the appropriate symbol, include ALL affected areas.

Ache: AAAA

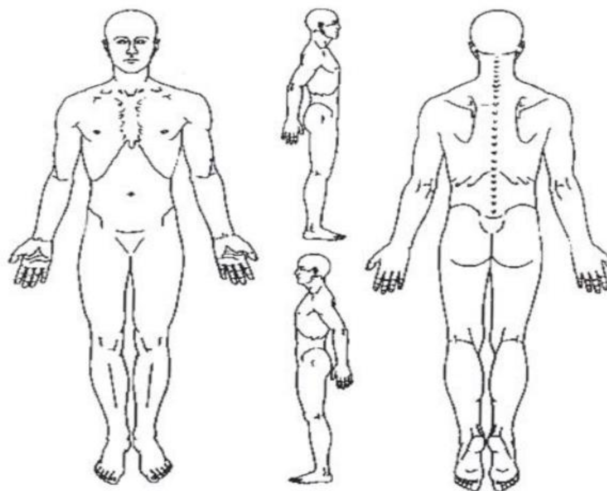
Numbness: NNNNN

Pins and Needles: PPPP

Burning: BBB

Stabbing: SSS

Throbbing: TTT



Using the scale provided below, rate your current level of pain:

(No pain) 0---1---2---3---4---5---6---7---8---9---10 (Debilitating)

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Dr. Sylvie Oliveira Dr. Colin Brown

Name: ____________________________________________ Date: ______________________

# HEALTH HISTORY

Please mark **C** beside the condition(s) you currently have
Please mark **P** beside the conditions you have had in the past

***Musculoskeletal System***

____ neck problems
____ jaw problems
____ upper back problems
____ shoulder problems
____ elbow / wrist problems
____ low back problems
____ ankle / foot problems
____ arthritis
____ osteoporosis
____ muscle soreness
____ scoliosis

***Nervous System***

____ headaches
____ loss of feeling
____ numbness
____ dizziness
____ fainting
____ loss of balance
____ confusion
____ depression
____ forgetfulness
____ fatigue
____ anxiety

***Systemic***

____ Diabetes
____ Hypoglycemia
____ Epilepsy
____ Rheumatoid
____ TB
____ HIV / AIDS
____ Cancer: ________
____ MS
____ Parkinson's
____ Thyroid problems
____ other: _________

***Ear, Eyes, Nose, Throat***

____ eye problems
____ vision problems
____ ear discharge
____ ear pain
____ ear ringing
____ hearing loss
____ sore throat
____ hoarseness
____ enlarged glands

***Circulatory system***

____ high blood pressure
____ high cholesterol
____ heart condition
____ aneurysm
____ stroke
____ varicose veins
____ diarrhea

***Pulmonary***

____ Asthma
____ chest pain
____ difficulty breathing
____ persistent cough

***Gastrointestinal system***

____ poor appetite
____ excessive hunger
____ abdominal pain
____ stroke
____ nausea / vomiting
____ diarrhea
____ constipation
____ black / bloody stool
____ liver trouble
____gallbladder trouble
____ weight trouble
____ ulcer

***Genito-Urinary system***

____ painful urination
____ excessive urination
____ scanty urine
____ discoloured urine
____ excessive thirst

***Allergies***

____ seasonal
____ hay fever
____ sinus pain
____ drug allergy
____ food allergy
____ other: ___________

***Female***

____ vaginal discharge
____ vaginal bleeding
____ pregnancy
____ menstrual pain
____ irregular cycle
Menopausal? □ Yes □ No
Pregnant? □ Yes □ No
Due date: ____________

***Men***

____ prostate problems

***Other:*** ______________
___________________

Any broken bones ? □ Yes □ No ______________________________
Any loss of consciousness ? □ Yes □ No ______________________________
Any accidents or injuries? □ Yes □ No ______________________________
Surgeries? □ Yes □ No ______________________________
______________________________

Name: ______________________________________________ Date: _______________________

## FAMILY HEALTH HISTORY

Please check any boxes that apply to anyone in your Family (not including you)

□ High blood pressure □ Rheumatoid Arthritis □ Breathing or lung problems □ Heart disease □ Osteoarthritis
□ Cancer: ____________________________ □ Stroke □ High cholesterol □ Neurological problems
□ Diabetes (Type I or Type II) □ Thyroid / Hormone problems □ Other: ____________________________

## HEALTH & LIFESTYLE

Your condition(s) may be affected by your environment, the foods you eat, and your lifestyle activities and habits. Please answer the following:

Please list any medications you are currently taking and for how long: _____________________________

________________________________________________________________________________

Please list any nutritional supplements you are currently taking and for how long: _____________________

________________________________________________________________________________

Do you exercise regularly? □ No □ Moderate □ Daily Activities: _______________________________

How would you describe your eating habits? □ Excellent □ Good □ Fair □ Poor

How many glasses of water do you drink per day? ____________________________________________

Do you Smoke? □ Yes □ No If yes, how long and how much? ____________________________________

Do you drink alcohol? □ Yes □ No If yes, how much? __________________________________________

Do you sleep well at night? □ Yes □ No If no, why? __________________________________________

Is your job stressful? □ Yes □ No If yes, why? _______________________________________________

Have you had any recent changes in body weight? □ Yes □ No If yes, how much? ___________________

List any major life stresses over the last year: _______________________________________________

List any enjoyable hobbies you participate in: _______________________________________________

## HEALTH GOALS

Are you satisfied with your current overall health? □ Yes □ No

What things would you like to change/improve about your current level of health? Please explain: _________

________________________________________________________________________________

What is preventing you from achieving your goals?

______________________________________________

Is there anything else that you are concerned about or would like advice about? ______________________

________________________________________________________________________________

***The information on this form is true to the best of my memory and I consent to further evaluation as deemed appropriate by the Chiropractor:***

______________________________________________ _______________________

Signature of patient or legal guardian Date

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