CHIROPRACTIC
CHADWICK CHUNG BSc, DC, FCCS(C)

601-89 Queensway Ave. West | Mississauga, ON L5B 2V2 | F: 905.281.9143 | T: 905.281.9898

General Information

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐
Surname:_____ Given Name:_____
Date of Birth: ____/____/_____ (mm/dd/yyyy) Age:_____ ☐ Married ☐ Divorced ☐ Widowed
Address: _____
City_____ Province_____ Postal Code_____
Phone #: Home: ( )_____ Work: ( )_____Cell: ( )_____
Leave messages? ☐ Yes ☐No If yes, please specify at which location ☐ Home ☐ Work ☐ Cell
Occupation: _____ Employer's Name: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone #: ( )_____

Healthcare Information

Medical doctor's name: _____ Phone #: ( )_____
Previous Chiropractor's name: _____ Phone #: ( )_____
Do you give authorization for the exchange of information with your healthcare providers? ☐ Yes ☐No
Do you have extended health care benefits? ☐ Yes ☐ No
If "Yes", what insurance company are your benefits with?_____

About your injury

Please specify the reason for today's visit: _____
Have you had this pain before? ☐ Yes ☐ No If "Yes", when: _____
How are the symptoms changing? ☐ Getting worse ☐ Staying the same ☐ Getting better

Is your injury as result of a work related accident? ☐Yes ☐ No
(If not, you do NOT have to fill in the following information)
What is your social insurance number?_____
WSIB claim number?_____ Date of accident: ____/____/_____ (mm/dd/yyyy)
Employer's name & telephone number: _____

Are your injuries related to a motor vehicle case? ☐Yes ☐ No
(If not you do NOT have to fill in the following information)
Date of accident: ____/____/_____ (mm/dd/yyyy)
Insurer's name & telephone number: _____
Policy claim #:_____

Is your injury sport related? ☐Yes ☐ No
If "Yes", What sport? _____

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Heath Information

1) Are you currently taking any medications (prescription or over the counter)? If "yes", please note:

Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____

2) Please check if you or any one of your family members have or have had any of the following, and if so how are they related?

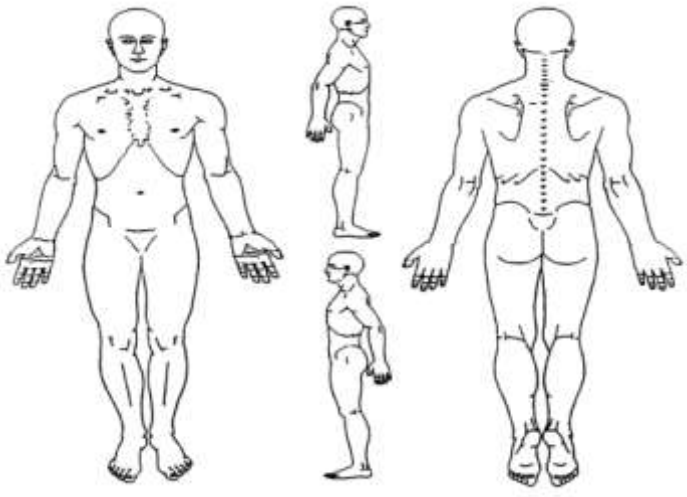
☐ Cancer Myself ____ Mother ____ Father ____ Sibling ____ Other (specify)_____
☐ Heart Disease Myself ____ Mother ____ Father ____ Sibling ____ Other (specify)_____
☐ Stroke Myself ____ Mother ____ Father ____ Sibling ____ Other (specify)_____
☐ Diabetes Myself ____ Mother ____ Father ____ Sibling ____ Other (specify)_____
☐ High Cholesterol Myself ____ Mother ____ Father ____ Sibling ____ Other (specify)_____
☐ Hypertension Myself ____ Mother ____ Father ____ Sibling ____ Other (specify)_____
☐ Other Myself ____ Mother ____ Father ____ Sibling ____ Other (specify)_____
Please specify any other condition(s): _____

3) Do you smoke? ☐ Yes ☐ No If "Yes", how many packs/day: ___ For How long?___
4) Do you consume alcohol? ☐ Yes ☐ No If "Yes", how many drinks/week: ____
5) Do you exercise? ☐ Yes ☐ No If "Yes", how many times/week: ____

Symptom Diagram

Please mark the areas on your body which represent the pain(s) or sensation (s) you are experiencing. Please include *all* areas. Use symbols provided below.

Numbness	≡≡≡≡≡
Pins & Needles	⁘⁘⁘⁘⁘
Dull & Aching	~~~~~ ~~~~~
Burning	XXXXX XXXXX
Sharp & Stabbing	////////// //////////
Stiff and Tight	22222 22222



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Numeric Pain Rating Scale

On the scale below, please indicate the intensity of the pain at its **LOWEST** and **HIGHEST** level:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Ever**

Health Status Survey

Please CIRCLE any condition that you CURRENTLY have and CHECK ☑ any that you have had in the PAST

General Symptoms
- ☐ Numbness or tingling
- ☐ Loss of feeling
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Confusion
- ☐ Depression
- ☐ Forgetfulness
- ☐ Seizures / Epilepsy
- ☐ Weight loss
- ☐ Fatigue
- ☐ Anxiety

Muscles and Joints
- ☐ Jaw problems
- ☐ Neck problems
- ☐ Upper back problems
- ☐ Shoulder problems
- ☐ Elbow / Wrist / Hand problems
- ☐ Lower back problems
- ☐ Knee / Ankle / Foot problems
- ☐ Arthritis or swollen joints
- ☐ Weakness or loss of strength

Skin
- ☐ Rashes / Itching
- ☐ Bruise easily
- ☐ Dryness
- ☐ Boils
- ☐ Hives

Circulatory - Respiratory
- ☐ Angina
- ☐ Pacemaker or similar
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Stroke
- ☐ Varicose veins
- ☐ Swelling ankles
- ☐ Persistent cough
- ☐ Coughing phlegm/blood
- ☐ Difficulty breathing

Eyes, Ears, Nose, Throat
- ☐ Blurred vision
- ☐ Failing vision
- ☐ Ear pain
- ☐ Ringing/Buzzing in ears
- ☐ Hearing loss
- ☐ Ear discharge
- ☐ Allergies
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Slurred speech
- ☐ Difficulty swallowing

Infections
- ☐ Fever
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes

Gastrointestinal
- ☐ Poor appetite
- ☐ Excessive hunger or thirst
- ☐ Nausea / Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder / Liver trouble
- ☐ Indigestion
- ☐ Diabetes

Genitourinary
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Scanty urine
- ☐ Discolored urine
- ☐ Bed wetting
- ☐ Prostate trouble
- ☐ Kidney troubles

Female Genitourinary
- ☐ Painful menstruation
- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Breast pain and/or lumps
- ☐ Irregular cycle

Have you ever taken the birth control pill?
☐ Yes ☐ No

Are you currently taking birth control pills? ☐ Yes ☐ No