

File Number: _____

CONFIDENTIAL PATIENT HEALTH RECORD

Name: _____ Date: _____

Name of Parent (s) if under 18: _____

We appreciate all referrals. How did you hear about our clinic? _____

Street Address: _____ City: _____

Postal Code: _____ Home Phone: _____ Work Phone: _____

Date of Birth (D/M/Y): _____ Age: _____ Sex: Male _____ Female _____

Marital Status: S M D W S Weight: _____ Height: _____ Handed: Lt Rt

Spouse's Name: _____ # of Children: _____

Your Occupation: _____ Your Employer: _____

Email: _____ Web Page: _____

Person Responsible for Payment: _____ Relationship: _____

Address of Payee: _____ Phone #: _____

Health Card Number: _____ Version / Letter Code: _____

Extended Health Care Company: _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment Options: Pay after each visit Pay visits in advance (pre-pay)

Is this a work related injury or accident? Yes No

Is this a motor vehicle related injury or accident? Yes No

Motor Vehicle Insurance Company: _____

Prior Chiropractic Care? Yes No Chiropractor: _____

Date of last treatment: _____ X-rays taken? Yes No Date: _____

Results of Care: Excellent Good Fair Poor

List any concerns about chiropractic care: _____

Medical Doctor's Name: _____ Location: _____

Date of last appointment: _____ Date of last physical: _____

REASONS FOR CONTACTING THIS OFFICE / WHAT ARE YOUR COMPLAINTS:

YOUR EXPECTATIONS FOR CARE: _____

ARE YOU LOOKING FOR: SHORT TERM CARE LONG TERM CARE

PATIENT HEALTH HISTORY

HISTORY OF CONDITION: *When* did your problem begin? _____

How did your problem begin? _____

Describe the **location** of your complaint / where is the problem: _____

How would you describe what *it feels like*? _____

If there are **pains or other sensations**, what are their character? (check all that apply)

- sharp stabbing dull aches sore weak
throbbing numbness shooting gripping burning tingling

Does the **pain spread** to other areas? (if so, where?) _____

Is the problem **affecting other areas** of your body? (if so, where?) _____

Have you had any **past or recent treatment** for this problem? Yes No

What **type of treatment**? _____

Have you done any **self-treatment** to help with the condition, and if so, what? _____

How bad is your discomfort? Please circle: **1 2 3 4 5 6 7 8 9 10**
no pain unbearable

How often is the complaint present? Constant (76-100% of the time)
 Frequent (51-75%) Occasional (26-50%) Intermittent (0-25%)

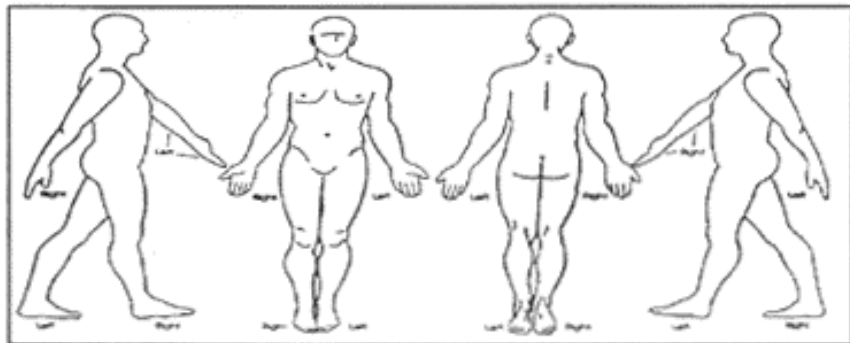
Since the problem began, is it: **Worsening** **Improving** **Not changing**

How long, if present, does the pain last? 1-2 hrs 2-5 hrs 5+ hours varies

What makes your problem **better**? Nothing Lying Down Walking Standing
 Sitting Movement/Exercise Inactivity Other: _____

What makes your problem **worse**? Nothing Lying Down Walking Standing
 Sitting Movement/Exercise Inactivity Other: _____

**MARK AN X
ON THE
PICTURES
WHERE YOU
HAVE PAIN OR
SYMPTOMS:**



Please read the following lists for conditions or problems you have had. Your answers will help detect areas or systems associated with your overall course of care.

Check any of the following diseases you have had in the past; circle those you currently have at this time:

- Pneumonia
- Mumps
- Influenza
- Rheumatic Fever
- Small Pox
- Pleurisy
- Polio
- Chicken Pox
- Arthritis
- Tuberculosis
- Diabetes
- Epilepsy
- Whooping Cough
- Cancer
- Mental Disorder
- Anemia
- Heart Disease
- Lumbago
- Measles
- Thyroid
- Eczema

MUSCULOSKELETAL

- Low Back Pain
- Gas / Bloating After Meals
- Pain Between Shoulders
- Heartburn
- Neck Pain
- Black / Bloody Stool
- Arm Pain / Leg Pain
- Colitis
- Joint Pain / Stiffness
- Walking Problems
- Difficult Chewing
- Jaw Clicking
- General Stiffness
- Bursitis
- Foot Trouble

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion / Depression
- Fainting
- Convulsions
- Cold / Tingling Arm / Leg
- Stress
- Allergy
- Chills
- Headaches
- Loss of Sleep
- Neuralgia
- Sweats
- Tremors

CARDIOVASCULAR & RESPIRATORY

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems
- Congestion
- Varicose Veins
- Ankle Swelling
- Stroke
- Hardening of Arteries
- Poor Circulation
- Chronic Cough
- Spitting Blood
- Wheezing / Asthma
- Fever
- Fatigue

EARS, EYES, NOSE, & THROAT

- Vision Problems
- Dental Problems

- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose
- Ringing In The Ear
- Sinus Infections
- Smell Changes
- Taste Changes
- Speaking Problems

GASTROINTESTINAL

- Appetite Changes
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramp / Pain
- Burping or Gas
- Jaundice / Yellow Skin

MALE / FEMALE

- Menstrual Irregularity
- Menstrual Cramping / Pain
- Vaginal Pain / Infections
- Breast Pain / Lumps
- Prostate / Sexual Dysfunction

GENTO-URINARY

- Bladder Trouble
- Painful / Excessive Urination
- Discolored Urine
- Bed Wetting
- Loss of Control Urination
- Kidney Infection
- Kidney / Bladder Stones

CONTINUE NEXT PAGE

SKIN

- Boils
- Bruise Easily
- Dryness
- Hive or Allergy
- Itching
- Skin Rash
- Acne

FEMALES ONLY

When was your last period?

Are you pregnant or is there a possibility you are pregnant?

- Yes No Not Sure

INTAKE (male and female)

- Coffee
 - Tea
 - Colas
 - Alcohol
 - Cigarettes
 - Vitamins / Supplements
 - Medications
- Meals per day 1 2 3 4

Please List **Medications**:

LIST ANY SURGICAL PROCEDURES:

Personal Satisfaction With

Diet:

- Highly Satisfied
- Satisfied
- Dissatisfied
- Highly Dissatisfied

Do you have a regular exercise program?

- Yes
- No

List activities / hobbies / things you like to do:

Is your current condition preventing you from doing any of the above?

- YES NO

Lifestyle / Work Stress

Levels:

- Extreme
- High
- Moderate
- Little

Hours of sleep per night? _____

Have you previously been hospitalized for anything?

- Yes
- No

Please list dates and reason:

List any falls or accidents, either recent or in the past:

Of the following diseases or disorders, please indicate if you or any relative has been troubled by the problem:

- High Blood Pressure _____
- Heart Attack / Stroke _____
- Cancer (any type) _____
- Diabetes _____
- Arthritis _____
- Angina _____
- Asthma _____
- Ulcers / Hernias _____
- Alzheimer's _____
- Back Problems _____

Have you had any recent colds, flu, illnesses, or diseases?

Are your complaints affecting your ability to work or be otherwise active?

- No effect
- Some physical restrictions (able to perform light work and tasks)
- Need limited assistance with common everyday tasks
- Need assistance often
- Have a significant inability to function without assistance
- Totally disabled / impaired. Cannot care for self.

PATIENT SIGNATURE:

DATE: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic x-rays by the doctor of chiropractic named below. This also applies to anyone working in this clinic authorized by the doctor of chiropractic listed below to provide said services with my prior knowledge and consent.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and I am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment including, but not limited to, muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Therefore, I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

TO BE COMPLETED BY THE PATIENT:

PRINT PATIENT'S NAME

SIGNATURE OF PATIENT
(OR PARENT/GUARDIAN IF UNDER 18)

DATE SIGNED

WITNESS TO ABOVE SIGNATURE

DR. DAVID E. KOIVURANTA
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TORONTO, ON M4V 1M7
416-961-1900

