



**HEALTH  
MATTERS  
CHIROPRACTIC  
CENTRE**

**Defining health to enhance life.**

Chiropractic, Physiotherapy, Massage Therapy & Acupuncture

3175 Rutherford Road, Suite 57, Vaughan, Ontario L4K 5Y6

Tel: (905) 532 0410 Fax: (905) 532 0413 Web: [www.enhancelife.ca](http://www.enhancelife.ca)

*An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law. You will be asked to provide written authorization for release of any information*

**PATIENT INTAKE FORM**

**Patient #:** \_\_\_\_\_

Date: \_\_\_\_\_

**Personal History**

Name: \_\_\_\_\_

First

Initial

Last

Address: \_\_\_\_\_

Street

Apt.

City

Province

Postal Code

Home phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ Bus. phone: (\_\_\_\_) \_\_\_\_\_ X \_\_\_\_\_

e-mail \_\_\_\_\_ Would you like to receive newsletters and updates via email:  Y  N

Birth date: (dd/mm/yyyy) \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Chiro/Physio experience:  Y  N

Business/Employer \_\_\_\_\_ Extended Health Coverage:  Y  N AMT: \_\_\_\_\_

Type of Work: \_\_\_\_\_ **Circle one:** Married Single Divorced Separated Other

Name and number of emergency contact: \_\_\_\_\_

Referred to us by?: \_\_\_\_\_

**Current Health Condition:**

What is your primary complaint?: \_\_\_\_\_

Other Health Professional seen for this condition:  Y  N Who? \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_ Has the condition occurred before:  Y  N

Is condition:  Job-related  Auto-related  Home injury  Fall  Other \_\_\_\_\_

Date of accident: (dd/mm/yyyy) \_\_\_\_\_ MVA:  Y  N WSIB:  Y  N Claim #: \_\_\_\_\_

What aggravates your condition?  Sitting  Standing  Bending  Lifting  Walking

Lying Down  Cold  Dampness  Other \_\_\_\_\_

What relieves your condition?  Bed rest  Ice  Heat  Massage  Medication

Other \_\_\_\_\_

Is your condition getting:  Worse  Constant  Comes and Goes  Better

Character of the pain:  Sharp  Dull  Ache  Pins and Needles  Numb

Burning  Constant  Intermittent  Other \_\_\_\_\_

Please describe how it feels when this problem is at its worst. \_\_\_\_\_

Please place an X on the grade indicating your severity of pain.

No pain \_\_\_\_\_ The Worst Pain you can imagine



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Patient Name: \_\_\_\_\_

**Patient #:** \_\_\_\_\_

Date: \_\_\_\_\_

*Please check the conditions that you are currently experiencing, or circle the condition that you have experienced often in the past.*

**General Symptoms**

- Headaches  
type: \_\_\_\_\_
- Loss of consciousness
- Blackouts
- Fever
- Sweats
- Fainting
- Dizziness
- Clumsiness
- Convulsions
- Loss of sleep
- Numbness, pain or tingling
- Nervousness
- Loss of weight

**Respiratory**

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficulty breathing

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Poor circulation
- Heart disease
- Angina
- Stroke
- Varicose veins
- Pain over heart
- Hardening of arteries
- Swelling of ankles
- Bleeding disorders

**Infections**

- Herpes
- Hepatitis
- Plantar warts
- TB
- HIV, AIDS
- Other: \_\_\_\_\_

**Skin**

- Skin conditions  
type: \_\_\_\_\_
- Bruise easily
- Rashes, itching
- Dryness
- Boils
- Hives

**Muscles and Joints**

- stiff neck
- back ache
- swollen joints
- Painful tailbone
- Foot trouble
- Shoulder pain
- Arm/Forearm pain
- Elbow pain
- Wrist pain
- Hand pain
- Arthritis
- affected areas \_\_\_\_\_
- Jaw (TMJ) pain or clicking
- Weakness or loss of strength

**E.E.N.T.**

- Blurred vision
- Failing vision
- Crossed eyes
- Double vision
- Eye pain
- Deafness
- Earache
- Ringing, buzzing, any noise in ears
- Asthma
- Frequent Colds
- Sinus infection
- Enlarged glands
- Enlarged thyroid
- Slurred or other speech problems
- Difficulty swallowing
- Dental problems

**Previous Chiropractor/Physiotherapist**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

**Medical Doctor**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

**X-rays in last 6 months:**  Y  N

Region(s) \_\_\_\_\_

**Have you ever had any fractures?**  Y  N

Region(s) \_\_\_\_\_

**Current Medications**

Name	For what condition?
_____	_____
_____	_____
_____	_____

**Genitourinary**

- trouble urinating
- Blood in urine
- Kidney infection
- Bed wetting
- Prostate trouble
- Sexual dysfunction

**Gastrointestinal**

- Indigestion
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting (blood?)
- Pain over stomach
- Constipation
- Diarrhea
- Hemorrhoids (piles)
- Jaundice
- Gall bladder trouble
- Intestinal worms
- Ulcer
- Diabetes
- Poor appetite

**Women**

- Painful
- Excessive Flow
- Hot Flashes
- Irregular cycle
- Cramps or backache
- Vaginal discharge
- swollen breasts
- Lumps in breasts

**Have you ever been on birth control?**  Y  N

**Are you currently taking the birth control pill?**  Y  N

# of pregnancies: \_\_\_\_\_

# of children: \_\_\_\_\_

**Are you Pregnant?**  Y  N

Due date: \_\_\_\_\_

**Lifestyle Stress Level**

- High
- Moderate
- Very Little

**Have you ever been in a car accident?**

Y  N When: \_\_\_\_\_

**Have you ever been hospitalized?**

Y  N Reason: \_\_\_\_\_

**Are you currently a smoker?**

Y  N

**Have you ever had surgery?**

Y  N Type: \_\_\_\_\_

**Have you ever smoked in the past?**

Y  N

**Have you ever been diagnosed with Cancer?**

Y  N Type: \_\_\_\_\_

**Do you have a regular exercise program?**

Y  N



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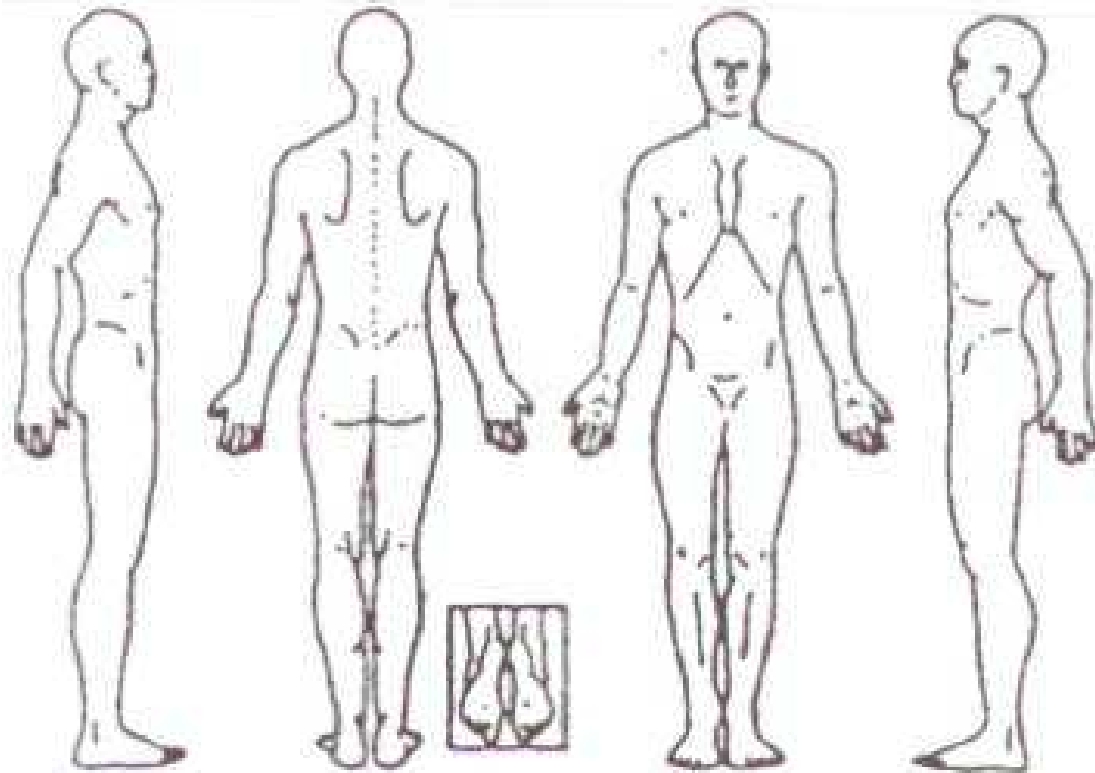
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**SYMPTOM DIAGRAM**



In the diagram provided, please mark the areas on your body, which you feel represent the pain(s) or sensation(s) you are experiencing. Please include all area. You may use the symbols provided below.

Symbols:	Numbness	nnnnnn	Pins and Needles	.....
	Burning	xxxxxx	Stabbing & Sharp	sssssss
	Dull & Aching	>>>>	Stiff & Tight	+++++