Name		Age	D.O.B (Day/Month/Year)	Sex Male ☐ Female ☐
Address		City		Postal Code
Email Address		Medical Doctors Name		
Home Phone ( )	Cell Phone ( )	Work Phone ( )		
Would you like: Call Reminder ☐ Text Reminder ☐ E-mail Reminder ☐ No Reminder ☐		Cell Phone Provider:		
Occupation:		Employer:		
Martial Status Single ☐ Married ☐ Divorced ☐ Widowed ☐	Spouses Name:	Spouses Occupation:	Do you have children? YES ☐ NO ☐	
Who can we thank for referring you?	Have you ever had chiropractic care before? YES ☐ NO ☐	Emergency Contact (name/phone #)		

Please indicate any significant slips, falls or motor vehicle accidents that have occurred over your life time.

1. Date ( ) ____

2. Date ( ) ____

Did any of these accidents occur while you were working? YES ☐ NO ☐

WORK HISTORY (Repetitive Strain Protocol)

My Current Occupation Involves:

Lifting (average weight) _______
Sitting: _____________ hours per day
Standing:_____________ hours per day
Driving: ___________ hours per day

Overhead Lifting **YES** ☐ **NO** ☐
Computer Work **YES** ☐ **NO** ☐

Repetitive work: ☐ Bending ☐ Twisting ☐ Lifting ☐ Fine Motor Skills

HEALTH HABITS

Did/do smoke ? Quantity ___________ **YES** ☐ **NO** ☐
Did/do drink alcohol? Quantity ________ **YES** ☐ **NO** ☐
Have you had surgery? **YES** ☐ **NO** ☐
Prescription Drugs? **YES** ☐ **NO** ☐
Recreational Drugs? **YES** ☐ **NO** ☐

Is There a Family History of:

Heart Disease	Yes	No
Diabetes	Yes	No
Stroke	Yes	No
Cancer	Yes	No
High Blood Pressure	Yes	No

What **medications** are you currently taking and for how long have you been consuming them?
____
____

307 Robinson Street, Oakville, ON, L6J 1G7, (T) 289-805-2252, (F) 289-805-2253

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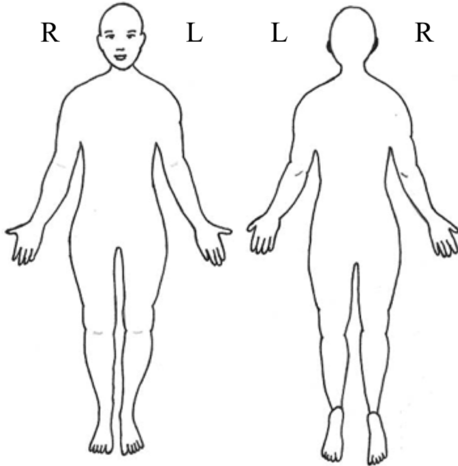
Circle your current level of pain, with 10 being the most severe and 1 being the least painful

1	2	3	4	5	6	7	8	9	10

Present Complaint ____
Pain or Problem when started ____
Pains are: ☐**Sharp** ☐**Dull** ☐**Constant** ☐**Intermittent**
Is the condition getting worse?☐**Yes** ☐**No**
Any Home Remedies? ____



Please fill the figure in with your current symptom pattern?

+ + +	Pain (dull)	- - -	Pain (sharp)
# # #	Numbness	* * *	Tingling (referral)
P P P	Pressure	C C C	Cramping

Other Symptoms

- ☐ Headaches
- ☐ Neck pain/stiffness
- ☐ Sleeping problems
- ☐ Back pain
- ☐ Nervousness
- ☐ Chest pains
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Loss of taste/smell
- ☐ Pins/Needles in Arms
- ☐ Pins/Needles in Legs
- ☐ Numbness in fingers
- ☐ Numbness in toes
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Depression
- ☐ Fever
- ☐ Significant weight loss
- ☐ Allergies/Asthma
- ☐ Diarrhea/Constipation
- ☐ Cold feet/hands
- ☐ Menstrual problems
- ☐ Loss of balance
- ☐ Stroke
- ☐ Fainting
- ☐ Night Sweats
- ☐ Foot Pain

For Women:
Are you pregnant YES ☐ NO ☐ Date of last menstrual cycle? _______________________
No. of Pregnancies _______ No. of Births _______ No. of Epidurals _______ No. of C- Sections _______

Patient Fee Schedule: New Patient Exam .... $90 Reassessment Exam ……. $90
Extended Visit ……. $65 Adjustment ……. $45

I, ________________________________, consent to a physical examination by the chiropractor.
Print Name

Signature ______________________________ **Date** ____________________________