

Last Name:		<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.		Marital status (circle one)	
First Name:		Middle:		<input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	
Email:		Birth date: DD / MM / YY		Age: Sex:	
Address:		City:		Postal Code:	
Home #:		OHIP #:			
Cell #:		How did you hear about us?			
Work#:		Employer:			
Spouse:		Children:			
Family Doctor: <input type="checkbox"/> No <input type="checkbox"/> Yes		Name of Doctor:		Tel:	
Address:		City:		Postal Code:	
Date of last Visit:		Date of last exam:			
Previous Chiropractor: <input type="checkbox"/> No <input type="checkbox"/> Yes		Name of Chiropractor:		Tel:	
Address:		City:		Postal Code:	
Date of last Visit:		Spinal X-Ray/Imaging History:			
Describe Chiropractic Experience:					
Surgeries List & Approx Dates:					
Present illness /Conditions: <input type="checkbox"/> venous insufficiency <input type="checkbox"/> varicose veins <input type="checkbox"/> tired/achy legs <input type="checkbox"/> swollen feet/legs <input type="checkbox"/> lymphedema					
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Degenerative disc / joint disease	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Respiratory
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Fibroids
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S	<input type="checkbox"/> Stroke/TIA
Describe conditions & list others:					
Family History of illness:					
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Mental/ Emotional	<input type="checkbox"/> Postural / Feet
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Osteoporosis
List family relationship, illness, age of diagnosis, details:					
Lifestyle: Your current weight: _____ lbs kg Your height: _____ in cm Your ideal weight: _____ lbs kg					
Alcohol <input type="checkbox"/> No <input type="checkbox"/> Yes		Cigarettes <input type="checkbox"/> No <input type="checkbox"/> Yes		Caffeine <input type="checkbox"/> No <input type="checkbox"/> Yes	
Drinks per day/wk:		Amt per day:		Drinks per day:	
				Exercise <input type="checkbox"/> No <input type="checkbox"/> Yes Hours per week:	
				(Circle one) Light / Moderate / Strenuous	
Describe your diet, lifestyle concerns & activity level:					
Reasons for joining our practice:		Your major complaint, health goals & conditions you hope will improve.			
<input type="checkbox"/> Wellness	<input type="checkbox"/> Pain	<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> Nerve Symptoms	<input type="checkbox"/> Injury Rehab	<input type="checkbox"/> Muscle Tension
<input type="checkbox"/> Posture	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Spinal Maintenance	<input type="checkbox"/> Custom Orthotics	<input type="checkbox"/> Extremity	<input type="checkbox"/> Sports Performance
<input type="checkbox"/> Sciatica					
<input type="checkbox"/> MVA / WSIB					
Describe your current complaints:					

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your chiropractic record.
I have stated all conditions that I am aware of accurately and will inform CCHC of any changes to my status.

Further Systems Review:			List any symptoms, health concerns or diagnoses not described elsewhere.		
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Yeast Infections	<input type="checkbox"/> Neuralgia/Numbness/Tingling	
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Chest pain/rapid beats	<input type="checkbox"/> Ear aches/noises	<input type="checkbox"/> Swelling/lymph	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Arteries hardening	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Colitis/Irritable bowel	<input type="checkbox"/> Gall bladder	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Gas/bloating	<input type="checkbox"/> Joint stiffness	<input type="checkbox"/> Bladder Dx
<input type="checkbox"/> Dry skin/rashes	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Loss of control of urine	<input type="checkbox"/> Kidney infection	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Prostate
Describe conditions & list others:					
Women Only:			Is there <i>any chance</i> that you might be pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes		
<input type="checkbox"/> Cramps	<input type="checkbox"/> PMS	<input type="checkbox"/> Irregular Cycle	<input type="checkbox"/> Painful Cycle	<input type="checkbox"/> Discharge	<input type="checkbox"/> Pregnant <input type="checkbox"/> Pre/Menopausal
Describe symptoms; Delivery due date; Menopause experience/dates:					
Musculo-Skeletal-Neurological Symptoms:					
<input type="checkbox"/> Wrist/hand R L	<input type="checkbox"/> Forearm R L	<input type="checkbox"/> Elbow R L	<input type="checkbox"/> Upper Arm R L	<input type="checkbox"/> Shoulder R L	
<input type="checkbox"/> Ankle/foot R L	<input type="checkbox"/> Lower leg R L	<input type="checkbox"/> Knee R L inner outer	<input type="checkbox"/> Thigh R L	<input type="checkbox"/> Hip R L	<input type="checkbox"/> Buttock R L
<input type="checkbox"/> Lower back R L	<input type="checkbox"/> Neck R L	<input type="checkbox"/> Upper back/blades R L	<input type="checkbox"/> Rib/side chest	<input type="checkbox"/> Tendonitis	<input type="checkbox"/> Spasms
<input type="checkbox"/> Visual disturbance	<input type="checkbox"/> Jaw pain/TMJ	<input type="checkbox"/> Numb/tingling legs or feet	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Numb/tingling arms or hands	
<input type="checkbox"/> Swelling	<input type="checkbox"/> Skin hypersensitive	<input type="checkbox"/> Tension top of shoulders	<input type="checkbox"/> Pain/ache/burn	<input type="checkbox"/> Numbness/loss of feeling? Where?	
<input type="checkbox"/> Neurologist visit	<input type="checkbox"/> Other specialist	<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Frozen shoulder	<input type="checkbox"/> Golfer's/Tennis Elbow	
Describe previous diagnoses, specialists, locations & symptoms further, if applicable:					
Sleep Posture & Habits:					
<input type="checkbox"/> Side sleeper	<input type="checkbox"/> Back sleeper	<input type="checkbox"/> Front sleeper	<input type="checkbox"/> Orthopedic pillow	<input type="checkbox"/> Well rested	<input type="checkbox"/> Fatigued
Describe sleep issues & pillow type/brand, if applicable:					
Ergonomics, Work & Play:			Consider what might be aggravating your current condition.		
Hours @ computer/games per day:	Hours sitting:	Hours standing:	<input type="checkbox"/> Heavy lifting	<input type="checkbox"/> Twisting/bending	
Other factors:	<input type="checkbox"/> Phone cradled neck	Rate stress: <input type="checkbox"/> high <input type="checkbox"/> moderate <input type="checkbox"/> low	"Self time" <input type="checkbox"/> N <input type="checkbox"/> Y		
Describe stress, list hobbies, work issues, ergonomic challenges:					
Supplements:					
High Quality Multivitamin <input type="checkbox"/> No <input type="checkbox"/> Yes	High Quality Omegas <input type="checkbox"/> No <input type="checkbox"/> Yes	Glucosamine for joints <input type="checkbox"/> No <input type="checkbox"/> Yes	Calcium/Mag/Vit D <input type="checkbox"/> No <input type="checkbox"/> Yes	Hormonal supplement <input type="checkbox"/> No <input type="checkbox"/> Yes	Other <input type="checkbox"/> No <input type="checkbox"/> Yes
Describe your supplements regimen:					
Falls, Accidents, Hospital visits, Meds:			List any recreational drug use, prescribed or OTC medications; length of use, condition & dosages.		
<input type="checkbox"/> Fall	<input type="checkbox"/> MVA	<input type="checkbox"/> Work Accident	<input type="checkbox"/> Emergency visit	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Unconsciousness <input type="checkbox"/> Medications
Drugs, conditions & dosages:					

24 hours notice required to cancel or change appointments.
 WE LOOK FORWARD TO SERVING YOU, IN YOUR HEALTH JOURNEY

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