pine+ Wellness Centre
MARKHAM-STOUFFVILLE

6-114 Anderson Ave, 2nd Floor
Markham, ON L6E 1A5
905-554-7681

For Office Use Only
FILE #:________
DOCTOR:________
DATE:________

Personal Infromation

Patient Name:____________________ ☐ M ☐ F Date of Birth: (D/M/YR)____________ Age:______

Street Address:____________________ City: ____________ Postal Code: __________

Home Phone:____________ Work #:____________ Cell #:____________

Email:____________ Is it okay to leave messages on your voicemail? ☐ Yes ☐ No

Family Physician:____________ Phone #:____________ Is it okay to follow up with your family physician? ☐ Yes ☐ No

Employer:____________ Occupation:____________ Previous Chiropractor:____________

Contact Person in case of emergency:____________________ Phone Number:____________

Is this a Workplace Injury (WSIB): ☐ Yes ☐ No Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No Date of Accident:________

Extended Health Care Coverage (EHC): Do you, your spouse, or guardian have medical coverage from work? (ie. dental, prescription, massage, chiropractic, physiotherapy, orthotics) ☐ Yourself ☐ Spouse ☐ Guardian ☐ No Insurance

Name of Insurance Company:____________________

Member/Policy Holder Name:____________________

Policy/Plan Number:____________________ Group ID Number: ____________

Name & Address of Employer:____________________

____

Phone Number:____________ Fax Number:____________

How did you hear about us?

☐ Medical Doctor Name________ ☐ Friend/Family Name ________ ☐ Clinic Employee Name ________

☐ Yellow Pages/Advert ☐ Pamphlet ☐ E-mail/Letter

☐ Website ☐ Walk-In ☐ Other:________

Patient Health History: Height:_____ Weight:_____

What is the main reason for your visit today? (please describe)____________________

____

When did it start? (date)________ Have you had this problem before? ☐ Yes ☐ No If YES, how long ago?________

On a scale of 1-10 (10 is the worst) how severe is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10

Have you had any of these treatments for this problem? ☐ Chiropractic ☐ Acupuncture ☐ Massage Therapy ☐ Injection ☐ Physical Therapy ☐ Cane/Crutch ☐ Medical Doctor

What tests/scans have you had for this problem? ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV) ☐ None

Do you currently experience: ☐ Fever ☐ Night Sweats ☐ Night Pain ☐ Weight Loss ☐ Loss of control of bowel/bladder ☐ None

Have you ever been knocked unconscious? ☐ Yes ☐ No

Have you ever broken any bones? ☐ Yes ☐ No

Have you ever been in a car accident? ☐ Yes ☐ No

Do you wear orthotics/arch supports? ☐ Yes ☐ No

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Patient Health History (cont'd):

Have you already had surgery for a problem in the same area either recently or in the past? ☐ Yes (Date) ______________ ☐ No

Current work status? ☐ Regular ☐ Light Duty (How long?______) ☐ Not working due to this problem
☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

Medical History (your health issues)

☐ **None** ☐ Cancer
☐ Hight blood pressure ☐ Stroke
☐ Heart disease ☐ Kidney disease
☐ Diabetes ☐ Liver disease
☐ Thyroid disease ☐ Arthritis
☐ Asthma ☐ Peptic Ulcer

Family History (what runs in your family)

☐ Heart Disease
☐ High Blood Pressure
☐ Diabetes
☐ Cancer
☐ Arthritis
☐ Osteoporosis
☐ Other:________________
☐ **None of the above**

Surgical History

Have you ever had surgery? ☐ Yes ☐ No
If yes, please list below:

______________________ date:______________
______________________ date:______________
______________________ date:______________
______________________ date:______________

Medications (please list your current medications and any medications you are taking for this problem)

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Allergies to Medications

☐ None
☐ Penicillin
☐ Sulfa
☐ Aspirin
☐ Codeine
☐ Other:______________

Vitamins/Natural Remedies

____
____
____
____

Lifestyle:

Are you currently a smoker? ☐ Yes ____ packs/day ☐ No
Have you ever smoked in the past? ☐ Yes ☐ No If Yes, When did you quit?______
Alcohol: ☐ None ☐ Occasional ☐ Frequent
Exercise: ☐ Yes ____ times per week for___ mins. ☐ No
Stress: ☐ Low ☐ Moderate ☐ High
Have you ever been hospitalized? ☐ Yes ☐ No

Female Patients:

Are you currently taking birth control pills? ☐ Yes ☐ No
Have you ever been on birth control pills? ☐ Yes ☐ No
# of pregnancies________ # of children ________
Is there any chance you may be pregnant? ☐ Yes ☐ No

Symptoms: Past and Present

- Please (circle) any conditions or symptoms *presently* causing you problems.
- Please **check** those conditions or symptoms which have been a problem to you in the *past*.

GENERAL SYMPTOMS
Loss of consciousness
Loss of balance
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of sleep
Numbness, pain or tingling
Weight Loss
Night Pain

MUSCLES & JOINTS
Stiff Neck
Back ache
Swollen Joints
Painful tail bone
Foot trouble
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Weakness or loss of strength
Osteoporosis

E.E.N.T.
Blurred vision
Failing vision
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

RESPIRATORY
Chronic cough
Spitting up blood
Chest pain
Difficulty Breathing

CARDIOVASCULAR
Bleeding disorder
High Blood Pressure
Pain over the heart
Stroke
Hardening of arteris
Varicose veins
Swelling of ankles
Poor Circulation
Angina

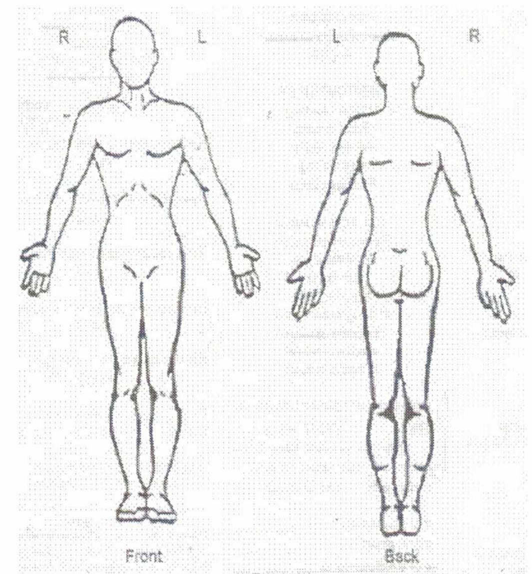
GASTROINTESTINAL
Indigestion
Nausea
Vomiting (blood?)
Constipation
Diarrhea
Hemorrhoids
Jaundice
Gall bladder trouble
Ulcer
Diabetes

SKIN
Rashes, itching
Bruise easily
Psoriasis

GENITOURINARY
Trouble Urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

G.U. FOR WOMEN
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps of backache
Lumps in breasts

Please use the diagrams below to indicate the location of your problem areas.



Rate your General Health Status:
☐ Excellent ☐ Good
☐ Fair ☐ Poor

I hereby declare that the above information is true. Signature: ______________ **Date:** ______________

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with other many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of the Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this ________ day of _________________ , 20 _____ .

____________________________	____________________________
Patient Signature (Legal Guardian)	Witness of Signature
Name: ________________________	Name: ________________________
(please print)	(please print)