

# ACTIVE FAMILY CHIROPRACTIC & WELLNESS CENTRE

4040 CREDITVIEW ROAD UNIT#23 / MISSISSAUGA / ONTARIO / L5C 3Y8 / (905) 804-8657

## CONFIDENTIAL PATIENT INFORMATION

Today's Date (D, M, Y): \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_  
Circle the following: Male / Female Married / Single Spouse's Name: \_\_\_\_\_  
Do you have children? Yes o No o What are their names/ ages? \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_ - \_\_\_\_  
Phone: Home: (\_\_\_\_) \_\_\_\_\_ Business: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_  
Date of Birth(D,M,Y): \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Do you have Extended Health Coverage : Yes / No If yes, amount eligible from insurance: \$ \_\_\_\_\_  
Please describe your physical complaint(s): \_\_\_\_\_  
\_\_\_\_\_  
How did you hear about our office? (Internet, Sign, Friend, Family, Doctor, Yellow Pages): \_\_\_\_\_

## HEALTH INFORMATION

Have you been to another Chiropractor? Yes/No  
If Yes; Chiropractor's Name: \_\_\_\_\_ When: \_\_\_\_\_  
Have you had spinal x-rays in the last 12 months? Yes o No o  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Number of Hours at Work per week? Hours/Week \_\_\_\_\_  
Hours of Sleep per Night? (Circle) 0-4 4-6 6-8 8-10 10+ Rate Appetite: (Circle) Poor Medium Excellent  
(Please Check Yes or No) Yes No  
1. Do you consume alcohol?  Yes  No  
2. Do you exercise?  Yes  No If yes, what kind of exercise & how often?  
\_\_\_\_\_  
3. Have you had any surgery?  Yes  No If yes, what kind & when?  
\_\_\_\_\_  
4. Have you been hospitalized?  Yes  No If yes, what for & when?  
\_\_\_\_\_  
5. Do you have a family history of cancer, diabetes or heart disease?  Yes  No If yes, who & what condition?  
\_\_\_\_\_  
6. Do you have a history of cholesterol, high blood pressure or aneurysm.  Yes  No If yes, which & when?  
\_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE CONTINUE NEXT PAGE™

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |                                               |                                          |                                           |                                        |
|-----------------------------------------------|------------------------------------------|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Polio            | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Whooping cough       | <input type="checkbox"/> Anemia          | <input type="checkbox"/> Measles          | <input type="checkbox"/> Mumps         |
| <input type="checkbox"/> Small pox            | <input type="checkbox"/> Chicken pox     | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Influenza        | <input type="checkbox"/> Pleurisy      |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Mental disorders | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Psoriasis       | <input type="checkbox"/> Eczema           |                                        |

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD WITHIN THE LAST SIX MONTHS**

MUSCULOSKELETAL

- Low back pain
- Hip or leg pain
- Upper back pain
- Shoulder pain
- Neck pain
- Arm pain
- Muscle tightness
- Joint pain/stiffness
- Walking problems
- TMJ problems

NERVOUS SYSTEM

- Headache
- Numbness
- Nervousness
- Paralysis
- Weakness
- Dizziness
- Fainting
- Forgetfulness
- Confusion/depression
- Convulsions
- Cold/tingling extremities
- Stress

GASTROINTESTINAL

- Poor/excessive appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gall bladder problems
- Weight trouble
- Abdominal cramping
- Gas/bloating after meals
- Heartburn
- Black/bloody stool
- Colitis
- Colic
- Ulcers

GENITOURINARY

- Bladder problems
- Painful / excessive urination
- Discoloured urine
- Prostate problems
- Sexual dysfunction
- Kidney stones
- Other\_\_\_\_\_

CARDIORESPIRATORY

- Chest pain
- Shortness of breath
- Blood pressure
- Irregular heartbeat
- Heart disease
- Lung problems
- Asthma
- Varicose veins
- Ankle swelling
- Stroke
- Smoker/  Non-Smoker

EENT

- Eye problems
- Allergies
- Ear aches/infection
- Hearing loss
- Sore throat
- Dental problems
- Stuffed nose
- Sinus problems

GENERAL

- Difficulty sleeping
- Fatigue
- Fever

GYNECOLOGIC

- Menstrual problems
- Vaginal pain/infection
- Breast pain/lumps
- Endometriosis/Fibroid
- Ovarian cyst

*Date of last period:*  
(D,M,Y)\_\_\_\_\_

*Are you pregnant?*  
 Yes  Not sure  
 No  Hysterectomy

**Patient's Signature:** \_\_\_\_\_

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