AXIS CHIROPRACTIC

304 Toronto St. S., #107, Uxbridge, ON L9P 1Y2
P: 905-852-9700 F: 905-852-6316
axischiropractic.ca

WELCOME TO AXIS CHIROPRACTIC

To enable us to assist you better, please complete ALL 4 PAGES of this form. Thank you.

PERSONAL INFORMATION

Name:_____ Gender: ☐ **Male** ☐ **Female**

Address:_____ City:_____ Postal Code:_____

Date of Birth: D_____ M_____ Y_____ Height: _____ Weight:_____

Phone: (Circle Primary) Home: _____ Cell:_____ Work:_____

Email:_____

Occupation:_____ Employer: _____

Would you describe your job as: ☐ Physically Demanding ☐ Sedentary

Spouse's Name:_____ No. of Children: _____ Ages: _____

REASON FOR CONSULTING THIS OFFICE

What is your primary complaint?_____

How long have you had this condition? _____ Has this happened before? ☐ **Yes** ☐ **No** When?_____

Is it a result of a motor vehicle accident? ☐ **Yes** ☐ **No** If yes, date of accident:_____

Is it a result of workplace injury? ☐ **Yes** ☐ **No** If yes, has the accident been reported at work? ☐ **Yes** ☐ **No**

Do you have Extended Health Insurance/Benefits? ☐ **Yes** ☐ **No**

What activities aggravate the condition? Check all that apply.

☐Sitting ☐Standing ☐Bending ☐Lifting ☐Walking ☐Sleeping ☐Weather Changes ☐Other:_____

Is it: ☐Getting Worse ☐Getting Better ☐Constant ☐Intermittent - Comes and Goes

How often does it happen? ☐Constant ☐Daily ☐Few times/week ☐Few times/month ☐Comes and Goes

Does it interfere with your: Check all that apply.

☐Work ☐Sleep ☐Daily Routine ☐Family/Social Time ☐Physical Activities/Sports ☐Other:_____

Describe the pain: Check all that apply.

☐Sharp ☐Dull ☐Ache ☐Pins & Needles ☐Numb ☐Burning ☐Other:_____

On a scale of 1-10 with 1 being NO pain and 10 being SEVERE pain, rate your pain level:_____

Do you feel the problem travels to other areas of your body? ☐ **Yes** ☐ **No** Which areas?_____

What relieves the condition? Check all that apply.

☐Ice ☐Heat ☐Massage ☐Stretches ☐Bed Rest ☐Walking ☐Medication ☐Other:_____

What do you believe is wrong with you?_____

Are there other areas of concern with your health? ☐ **Yes** ☐ **No** Please describe: _____

Other doctors/therapists seen for these conditions? ☐ **Yes** ☐ **No** If yes, who/type of practitioner(s) and when:_____

_____

How long has it been since you felt very good?_____

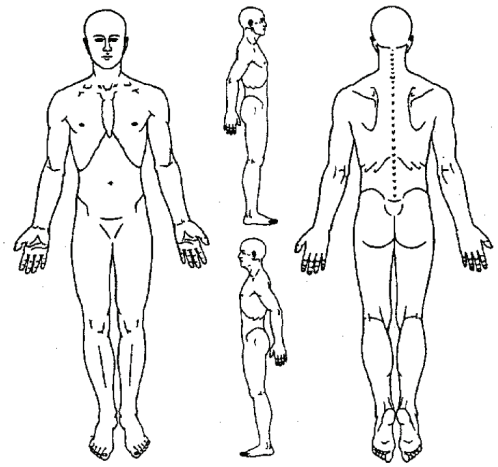
People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (**Preventative Care**). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Preventative Care ☐ Check here if you want your doctor to select the type of care appropriate for your condition.

Using the following symbols, indicate the area(s) of pain or unusual feeling:

Numbness	>>>>>> >>>>>>
Pins & Needles	0000000 0000000
Burning	XXXXXX XXXXXX
Aching	******** ********
Throbbing	////////// //////////



HEALTH HISTORY

Check any of the following symptoms/conditions which you now have or have had in the past.

GENERAL
- ☐ Allergy
- ☐ Anxiety/Depression
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Neuralgia
- ☐ Numbness
- ☐ Sweats
- ☐ Tremors

MUSCLES & JOINT
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot Trouble
- ☐ Hernia
- ☐ Low Back Pain
- ☐ Neck Pain or Stiffness
- ☐ Pain Between Shoulders
- ☐ Painful Tail Bone
- ☐ Poor Posture
- ☐ Sciatica
- ☐ Spinal Curve
- ☐ Swollen Joints

Pain or Numbness in:
- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

Other: _____

GASTRO-INTESTINAL
- ☐ Belching or Gas
- ☐ Colitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Nausea
- ☐ Stomach Pain
- ☐ Vomiting

Other: _____

EYES, EARS, NOSE & THROAT
- ☐ Asthma
- ☐ Frequent Colds
- ☐ Deafness
- ☐ Earache
- ☐ Eye Pain
- ☐ Hay Fever
- ☐ Nasal Obstruction
- ☐ Sinus Infection
- ☐ Sore Throat

Other: _____

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Poor Circulation
- ☐ Swelling of Ankles

Other: _____

RESPIRATORY
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Asthma
- ☐ Difficulty Breathing
- ☐ Wheezing

Other: _____

SKIN
- ☐ Bruise Easily
- ☐ Dryness
- ☐ Hives or Allergy
- ☐ Itching
- ☐ Skin Eruptions (Rash)
- ☐ Varicose Veins

Other: _____

GENITO-URINARY
- ☐ Bed-wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Kidney Infection or Stones
- ☐ Painful Urination
- ☐ Prostate Problems

Other: _____

FOR WOMEN ONLY
- ☐ Cramps or Backache
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Lumps in Breast
- ☐ Menopausal Symptoms
- ☐ Painful Menstruation
- ☐ Miscarriage

Other: _____

CONDITIONS
- ☐ Asthma
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart Disease
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ Stroke
- ☐ Ulcers

Other: _____

Do you have a regular exercise program? ☐ **Yes** ☐ **No** What type and how often? _____

Age of mattress? _____ Is it comfortable? ☐ **Yes** ☐ **No**

Do you currently smoke? ☐ **Yes** ☐ **No** How much and for how long? _____

Have you ever smoked? ☐ **Yes** ☐ **No** When did you quit? _____

On a scale of 1-10 with 1 being NO stress and 10 being SEVERE stress, rate your stress level: _____

Have you ever had chiropractic care? ☐ **Yes** ☐ **No** Reason for visit: _____

Date of last chiropractic visit: _____ Name of Chiropractor: _____

Name of your Medical Doctor: _____

Check if you have ever:

☐ Experienced loss of consciousness(concussion) Briefly Describe _____

☐ Used a cane, crutch, other support Briefly Describe _____

☐ Had a fractured bone Briefly Describe _____

☐ Been hospitalized for other than surgery Briefly Describe _____

List surgical operations and dates:

_____

_____

_____

Date of last:

CT Scan _____ Spinal Exam _____

MRI _____ Physical Exam _____

Bone Density Scan _____ Blood Test _____

Bone Scan _____ Spinal X-Ray _____

Dental Visits ☐ Semi-annual ☐ Yearly ☐ Emergency Only ☐ Other: _____

Are you wearing ☐ Heel Lifts ☐ Insoles ☐ Custom Orthotics

Have you ever been in an automobile accident? ☐ No ☐ Past year ☐ Past 5 years ☐ 5+ years

Decribe impact on you _____

Have you ever had any other personal injury or accident? ☐ No ☐ Past year ☐ Past 5 years ☐ 5+ years

Describe _____

MEDICATION AND SUPPLEMENTS

Do you have an allergy to any drugs? ☐ **Yes** ☐ **No** Specify: _____

List the medications you are currently taking:

_____ _____

_____ _____

_____ _____

List the natural supplements you are currently taking:

_____ _____

_____ _____

_____ _____

FAMILY HEALTH HISTORY

Health problems may have a connection to family history. This information about your family members will give us a better picture of your total health.

Does any member of your family suffer from the same condition as you have now? ☐ **Yes** ☐ **No**

If yes, whom? _____

Check if you have family history of any of the following:

Condition	Relationship to You	Condition	Relationship to You
☐ Heart Disease	_____	☐ Hypertension	_____
☐ Arthritis	_____	☐ Stroke	_____
☐ Osteoporosis	_____	☐ Obesity	_____
☐ Cancer	_____	☐ Other:	_____
☐ Diabetes	_____	☐ Other:	_____

REFFERALS

Referrals are the highest compliment we can be paid. Please tell us how you heard about our office: Check all that apply.

☐ Patient - Name: _____	☐ Website	☐ Our Sign/Location
☐ Advertisement - Which one: _____	☐ Facebook	☐ Google Search
☐ Health Practitioner - Name: _____	☐ Yellow Pages	☐ Other: _____
☐ Other Individual - Name: _____	☐ Phone Book	

PAYMENT

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Would you like to receive our health and wellness newsletter via email? ☐ Yes ☐ No
You may unsubscribe at any time.

Signature of Patient: _____ **Date:** _____

If patient is a minor, name of Parent/Guardian: _____

Signature of Parent/Guardian: _____