Orleans Gardens Chiropractic **_(613) 830-3337_**

1615-6 Orleans Blvd, Orleans, Ontario, K1C 7E2 **_www.orleansgardenschiro.com_**

CONFIDENTIAL HEALTH RECORD

Welcome to our office! Please complete all questions. Thank You.

Name:			Date:
Address:			Postal Code:
City:	Email:		
Home Phone:	Work Phone:		Cell Phone:
Birth date: (D / M / Y)			Age:
Sex: M F			Marital Status: M W D S
Your Employer:			Occupation:
Spouse's Name			Spouse's Employer:
Children's Names and Ages:			
Sports, Hobbies or Interests:			
Hours of exercise / week (walk, jog, weights, yoga / pilates…)			
Extended Health Insurance Company:			
Have you received previous Chiropractic care Y ☐ N ☐ If yes, date of last visit and reason for consulting			
Name of your Medical Doctor			

Who may we thank for referring you? ____

Current health complaints / reasons for consulting our office:

1. ____ When did it start? ______________________
2. ____ When did it start? ______________________

Please mark your pain *(no pain)* 0---10 *(unbearable pain)*

Have you had the same or similar problem(s) before Y ☐ N ☐ If yes, when?__________________________________

Is this the result of an auto injury? * Y ☐ N ☐ If so when?____

**Should today's visit be a result of a recent auto accident, please notify our front desk assistant.*

Is this the result of a work injury? Y ☐ N ☐ *If so please be advised that this office does not accept WSIB claims.*

Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Other ____________________________________

Does it interfere with your: ☐ Sleep ☐ Work ☐ Exercise ☐ Household Chores ☐ Other___________________

Does it radiate (move anywhere)? Y ☐ N ☐ If yes, where? ____

What makes it worse ____

Other professionals seen for this condition ____

Treatment given/ recommended____

HEALTH HISTORY (please list)

Hospitalizations or surgeries:____

Diagnosed Medical conditions: ____

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Medications you are currently taking? ____

Are you suffering from any mental conditions:____

Have you ever received any emergency care Y ☐ N ☐ If yes describe,______________________

____

PRESENT HEALTH: Are you affected by any of the following? (within past 6 months)

☐ Low Back Pain	☐ Headaches	☐ Jaw Pain	☐ Heartburn	☐ Menstrual Pain
☐ Tail Bone Pain	☐ Migraines	☐ Buzzing in Ears	☐ Indigestion/ Vomiting	☐ Cold Sweats
☐ Hip Pain	☐ Neck Pain	☐ Vision Changes	☐ Constipation	☐ Breast Pain
☐ Groin Pain	☐ Shoulder Pain	☐ Loss of Smell	☐ Diarrhea	☐ Mood Swings
☐ Knee Pain	☐ Pain between Shoulder Blades	☐ Sinus Infection	☐ Bloating/ Gas	☐ Nervousness
☐ Ankle Pain	☐ Elbow Pain	☐ Ear Infection	☐ Abdominal Ulcers	☐ Tension
☐ Plantar Fasciitis	☐ Wrist Pain	☐ Fever	☐ Chest Pain	☐ Hot Flashes
☐ Numbness Legs	☐ Hand Pain	☐ Loss of Balance	☐ Heart Palpitations	☐ Fainting
☐ Weakness Legs	☐ Numbness Arms	☐ Dizziness	☐ Asthma	☐ Weight Gain
☐ Cold Feet	☐ Weakness Arms	☐ Poor Sleep	☐ Bronchitis	☐ Weight Loss
☐ Pins & Needles Leg/Feet	☐ Cold Hands	☐ Fatigue	☐ Pneumonia	☐ Irritable Bowel
☐ Phlebitis	☐ Pins & Needles Arm/ Hand	☐ Depression	☐ Blood Pressure Changes	☐ Colitis
Stress Level_____/10	☐ Rib Pain	☐ Forgetfulness	☐ Heart/ Lung Conditions	☐ Bladder Trouble

HISTORY OF TRAUMAS

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO
As a child have you fallen/jumped from a height greater than 3 feet (i.e. bunk bed, play structure)	☐	☐
Were you dropped as a child?	☐	☐
Have you had impacts downhill skiing/ snowboarding?	☐	☐
As an adult did you have any serious falls?	☐	☐
Have you ever had any work injuries?	☐	☐
Did you play youth contact sports?	☐	☐
Have you ever had any sport injuries?	☐	☐
Have you ever sustained a head trauma?	☐	☐
Have you broken any bones?(list)______________	☐	☐
Have you received any stitches? (other than surgery)	☐	☐
Have you ever had crutches for more than 1 week?	☐	☐

Have you been in an automobile accident? ☐ No ☐ Past year ☐ 2 to 5 years ☐ Over 5 years

Describe the accident(s)____

INTAKE (please indicate quantity / day)

Coffee________ Caffeinated teas______ Glasses of water______ Colas_______

Alcohol_____/d _____/w Cigarettes________ Hours of sleep________

I sleep on my: ○ side ○ back ○ stomach