

# NOTTINGHILL FAMILY WELLNESS CENTRE

905-827-4197

www.glenabbeychiro.com

Name		Age	D.O.B DD ____ MM ____ YY ____	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Address			City	Postal Code
Email Address			Medical Doctors Name	
Home Phone ( )	Cell Phone ( )		Work Phone ( )	
Would you like: Text Reminder <input type="checkbox"/> OR E-mail Reminder <input type="checkbox"/>			Who can we thank for referring you? Google <input type="checkbox"/> Physician <input type="checkbox"/> Other <input type="checkbox"/> _____	
Occupation:			Employer:	
Do you have any private insurance? If yes: Manulife <input type="checkbox"/> Great West Life <input type="checkbox"/> Sunlife <input type="checkbox"/> Other <input type="checkbox"/> _____			Marital Status (For insurance purposes) : Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>	
Spouse Name (For insurance purposes):	Have you had chiropractic care before? YES <input type="checkbox"/> NO <input type="checkbox"/>		Emergency Contact (Name/Phone No.)	

Please indicate any significant slips, falls or motor vehicle accidents that have occurred over your life time.

1. Date ( ) \_\_\_\_\_

2. Date ( ) \_\_\_\_\_

Did any of these accidents occur while you were working? YES  NO

## WORK HISTORY (Repetitive Strain Protocol)

### My Current Occupation Involves:

Lifting (average weight): \_\_\_\_\_ Overhead Lifting YES  NO   
 Sitting: \_\_\_\_\_ hours per day Computer Work YES  NO   
 Standing: \_\_\_\_\_ hours per day  
 Driving: \_\_\_\_\_ hours per day

Repetitive work:  Bending  Twisting  Lifting  Fine Motor Skills

## HEALTH HABITS

Did/do smoke ? Quantity \_\_\_\_\_ YES  NO   
 Did/do drink alcohol? Quantity \_\_\_\_\_ YES  NO   
 Have you had surgery? YES  NO   
 Prescription Drugs? YES  NO   
 Recreational Drugs? YES  NO

### Is There a Family History of:

Heart Disease	Yes	No
Diabetes	Yes	No
Stroke	Yes	No
Cancer	Yes	No
High Blood Pressure	Yes	No

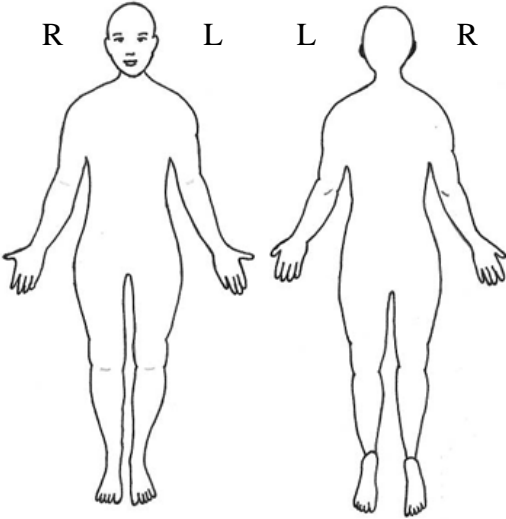
What **medications** are you currently taking and for how long have you been consuming them?

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**Circle your current level of pain, with 10 being the most severe and 1 being the least painful**

1	2	3	4	5	6	7	8	9	10
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Present complaint \_\_\_\_\_  
 Pain or problem started when \_\_\_\_\_  
 Pains are:  Sharp     Dull     Constant     Intermittent  
 Is the condition getting worse?  Yes     No  
 Any Home Remedies? \_\_\_\_\_



**Please fill the figure in with your current symptom pattern?**

+++ Pain (dull)	--- Pain (sharp)
### Numbness	*** Tingling (referral)
PPP Pressure	CCC Cramping

**Other Symptoms**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Pins/Needles in Arms    | <input type="checkbox"/> Allergies/Asthma      |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Pins/Needles in Legs    | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Sleeping problems   | <input type="checkbox"/> Numbness in fingers     | <input type="checkbox"/> Cold feet/hands       |
| <input type="checkbox"/> Back pain           | <input type="checkbox"/> Numbness in toes        | <input type="checkbox"/> Menstrual problems    |
| <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Loss of balance       |
| <input type="checkbox"/> Chest pains         | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Depression              | <input type="checkbox"/> Fainting              |
| <input type="checkbox"/> Ringing in ears     | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Night Sweats          |
| <input type="checkbox"/> Loss of taste/smell | <input type="checkbox"/> Significant weight loss | <input type="checkbox"/> Foot Pain             |

**For Women:**

Are you pregnant YES  NO  Date of last menstrual cycle? \_\_\_\_\_  
 No. of Pregnancies \_\_\_\_\_ No. of Births \_\_\_\_\_ No. of Epidurals \_\_\_\_\_ No. of C- Sections \_\_\_\_\_

**Patient Fee Schedule:**    New Patient Exam ..... \$75.00    Reassessment Exam ..... \$70.00  
    Acute Injury Treatment .... \$50.00    Adjustment ..... \$39.00

**Initial** x \_\_\_\_\_

**\*\* all prices subject to change without notice**

Please make the doctor aware if you are HIV positive or if you any other communicable disease.

I, \_\_\_\_\_, consent to a physical examination by the chiropractor.  
    **Print Name**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_