NOTTINGHILL FAMILY WELLNESS CENTRE

905-827-4197 www.glenabbeychiro.com

Name	**Age**	**D.O.B** **DD_____ MM_____ YY_____**	**Sex** **Male ☐ Female ☐**
Address		**City**	**Postal Code**
Email Address		**Medical Doctors Name**	
Home Phone **( )**	**Cell Phone** **( )**		**Work Phone** **( )**
Would you like: **Text Reminder ☐ OR E-mail Reminder ☐**		**Who can we thank for referring you?** **Google ☐ Physician ☐ Other ☐ _____**	
Occupation:		**Employer:**	
Do you have any private insurance? If yes: **Manulife ☐ Great West Life ☐ Sunlife ☐ Other ☐_____**		**Marital Status (For insurance purposes) :** **Single ☐ Married ☐ Divorced ☐ Widowed ☐**	
Spouse Name (For insurance purposes):	**Have you had chiropractic care before?** **YES ☐ NO ☐**	**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): _____
Sitting: _____ hours per day
Standing:_____ hours per day
Driving: _____ hours per day

Overhead Lifting **YES ☐ NO ☐**
Computer Work **YES ☐ NO ☐**

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?

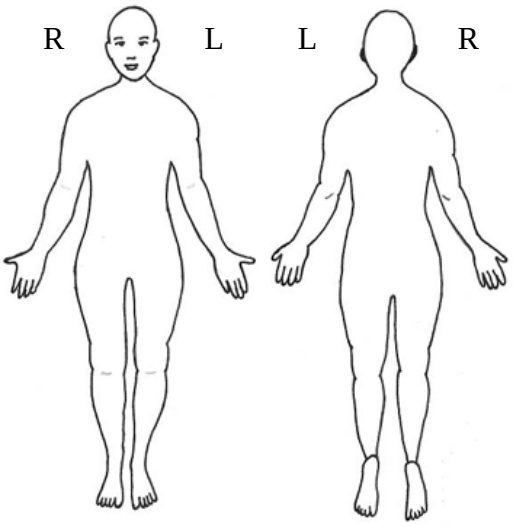
_____

_____

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

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)
P P P	Pressure	C C C	Cramping

Other Symptoms

☐ Headaches	☐ Pins/Needles in Arms	☐ Allergies/Asthma
☐ Neck pain/stiffness	☐ Pins/Needles in Legs	☐ Diarrhea/Constipation
☐ Sleeping problems	☐ Numbness in fingers	☐ Cold feet/hands
☐ Back pain	☐ Numbness in toes	☐ Menstrual problems
☐ Nervousness	☐ Shortness of breath	☐ Loss of balance
☐ Chest pains	☐ Fatigue	☐ Stroke
☐ Dizziness	☐ Depression	☐ Fainting
☐ Ringing in ears	☐ Fever	☐ Night Sweats
☐ Loss of taste/smell	☐ Significant weight loss	☐ 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 ..... $85.00 Reassessment Exam $80.00
Acute Injury Treatment .... $50.00 Adjustment $40.00

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** _____