UNIVERSAL
CHIROPRACTIC

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Phone: 905-567-8535 Fax: 905-567-8232

Thank you for choosing our office!

To ensure your visit with us is a pleasant one, here are the procedures you can expect upon arrival.

Paperwork Please complete this questionnaire and your health history to help us to get to know you. The doctor will use this information to help formulate recommendations for your care.

Consultation You will meet the doctor and our New Patient Advocate. The doctor will review your health history and determine if yours is a chiropractic case. You will be informed of any of the fees for office procedures before they are performed.

Examination Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause(s) of your subluxations.

Spinal Images Necessary views may be taken to visualize the location of any spinal problems, neurological interferences, reveal any pathologies, and make your chiropractic care more precise.

Correlation Before proper care can be rendered; the doctor will study your examination findings. Later, you will see x-rays, review your findings and receive specific care and recommendations from the Doctor.

CONFIDENTIAL PATIENT INFORMATION AND CASE HISTORY

☐ **Mrs**. ☐ **Ms.** ☐ **Miss**. ☐ **Mr**. How would you like to be addressed? _____

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Home phone:_____ Business phone: _____ Ext. _____ Cell phone: _____

Email: _____ Date of Birth : ____/____/_____ Sex ☐ M ☐ F
m d yy

Age: _____ Shoe Size: _____ Weight: _____lb Occupation: _____

Employed by: _____ Number of children: _____ Ages: _____

Marital Status ☐ single ☐ married ☐ divorced ☐ widowed ☐ serious relationship

Who may we thank for referring you to our office? _____

Name and number of Medical Doctor: _____

Females only, are you pregnant? YES NO Due date: _____

Do you have extended health insurance? ☐ yes ☐ no

Annual health insurance coverage for chiropractic: _____ Orthotics: _____

What is your major complaint for which you are seeking chiropractic care? _____

_____

Name_____

SOURCES OF SPINAL STRESS

To help us determine the cause of your problem, please indicate on this page, potential sources of spinal trauma.

1. Birth – with respect to **<u>your own</u>** birth process, please check all that apply:

- ☐ Natural
- ☐ Epidural/Drug-induced
- ☐ Not Sure
- ☐ Premature
- ☐ C-section
- ☐ Breech
- ☐ Cord around neck
- ☐ Forceps
- ☐ Prolonged delivery
- ☐ Vacuum Extraction
- ☐ Pulling/twisting by delivery doctor

Did **<u>your mother</u>** sustain any falls, accidents, or injuries during pregnancy?

☐ Yes ☐ No ☐ Not Sure

2. Childhood accidents/injuries—check all that apply:

- ☐ Fell down _____ Injuries: _____
- ☐ Sports injury Injuries: _____
- ☐ Moving vehicle accident Injuries: _____
- ☐ Physical Fight Injuries: _____
- ☐ Other_____ Injuries: _____
- ☐ Other_____ Injuries: _____

3. Adulthood accidents/injuries:

- ☐ Fell down _____ Injuries: _____
- ☐ Sports injury Injuries: _____
- ☐ Moving vehicle accident Injuries: _____
- ☐ Physical Fight Injuries: _____
- ☐ Other_____ Injuries: _____
- ☐ Other_____ Injuries: _____

4. Please list any *major* operations/illnesses you've had and their approximate dates.

_____

_____

5. Auto Accidents: Have you ever, even as a passenger, even if you did not think you were hurt, been involved in a car accident or near collision?

☐ Yes ☐ No

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Name:_____

Date: _____

Description of accident:

_____

_____

Speed of collision:_____

Severity of damage:_____

Injury after accident:_____

Physical Examination by:_____

X-rays taken (approximate date):_____

Date: _____

Description of accident:

_____

_____

Speed of collision:_____

Severity of damage:_____

Injury after accident:_____

Physical Examination by:_____

X-rays taken (approximate date):_____

If you answered **yes to question 5**, please fill in:

6. Please list any medication (prescription or over-the-counter) that you've taken in the past 6 months along with their frequency.

_____

_____

7. Primary Daily Activities – constant poor posture will lead to spinal stresses.

☐ Sitting ☐ Walking ☐ Telephone

☐ Standing ☐ Desk/Computer work ☐ Manual Repetitive Work

☐ Driving ☐ Heavy labour ☐ Other _____

The following questions apply to the major concern that you have come in for.

8. Where is the location of your major complaint? _____

☐ Left ☐ Right ☐ Center ☐ Both sides ☐ Upper ☐ Lower

9. How long has this been going on? _____

10. Spinal stress can generate **different types of discomfort throughout the body**. How would you describe what you feel?

☐ Burning ☐ Diffuse ☐ Dull / Aching ☐ Sore

☐ Stabbing ☐ Tingling ☐ Radiating ☐ Other _____

☐ Sharp ☐ Shooting ☐ Localized

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Name:_____

11. Spinal stress can also **choke on the nerves** to cause the pain to **travel** to different parts of the body. For example, neck pain can travel down into the shoulders or arms; low back pain can travel down into the legs. Have you experienced any travelling pain?

☐ Yes ☐ No If yes, **from** _____ **to** _____
(Please indicate side of body)

12. Spinal stress can put pressure on and off the spinal cord and nerves, causing symptoms to come and go over time. Is your condition **CONSTANT** or **INTERMITTENT**? (Circle one)

13. Circle on a scale of 1-10 how you would rate your discomfort:

No Pain				Moderate Pain					Extreme Pain
1	2	3	4	5	6	7	8	9	10

14. What have you found that **aggravates** your symptoms?

_____

15. What have you found that **relieves** your symptoms?

_____

16. Who have you **already seen** in an attempt to correct this problem? (ex. Chiropractors, physiotherapists, etc)

_____

17. How has it affected your life? What are you hoping to improve in your life with chiropractic care? That is, what would you like to **start doing** or **do more of** if you were feeling 100%?

_____

18. How **committed** are you to achieving **optimal health**?

Not committed				Moderately committed					100% committed!
1	2	3	4	5	6	7	8	9	10

19. What is **most important to you** in a relationship with our clinic? (**Please check <u>only one</u>**)

☐ Time ☐ Trust/Honesty ☐ Communication ☐ Other _____

☐ Finances ☐ Results ☐ Friendliness

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Name:_____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in your lowered state of health. At your report of findings, Dr. Wolfs or Dr. Suek will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Past Health: Have you ever suffered from any of the following conditions?

	Yes	No		Yes	No		Yes	No
Thyroid trouble ……..	☐	☐	Tuberculosis……	☐	☐	Emotional problems…	☐	☐
Diabetes…….....	☐	☐	Pneumonia…….....	☐	☐	Epileptic seizures……	☐	☐
High blood pressure……	☐	☐	Back Pain……	☐	☐	Asthma……	☐	☐
Heart disease……	☐	☐	Headaches……...	☐	☐	Arthritis……..	☐	☐
Allergies……	☐	☐	Stomach ulcers……	☐	☐	Alcoholism…….	☐	☐
Psoriasis……..	☐	☐	Polio…….....	☐	☐	Cancer ……...	☐	☐
Venereal Disease…….	☐	☐	HIV……..	☐	☐	Heart Attack……...	☐	☐
						Stroke…….	☐	☐

Present Health: Are you presently affected by any of the following? (Within the past 3 months)

Please check the boxes: O - OCCASIONAL F - FREQUENT C - CONSTANT

MUSCLE AND JOINT	O	F	C
Neck Pain……	☐	☐	☐
Shoulder Pain……..	☐	☐	☐
Low Back Pain…….	☐	☐	☐
Knee trouble……	☐	☐	☐
Foot trouble …….	☐	☐	☐
Arthritis……...	☐	☐	☐
Hernia……..	☐	☐	☐
Spinal curvature……...	☐	☐	☐
Faulty posture……..	☐	☐	☐
Sciatica……..…......	☐	☐	☐
Painful tailbone……...	☐	☐	☐

CARDIOVASCULAR	O	F	C
Rapid heart beat…….. ..	☐	☐	☐
High blood pressure……...	☐	☐	☐
Low blood pressure…….....	☐	☐	☐
Pain over heart……...	☐	☐	☐
Swelling of ankles……..	☐	☐	☐
Poor circulation…….....**yes** ☐ **no** ☐			

GENERAL SYMPTOMS	O	F	C
Fever/chills/sweating …….....	☐	☐	☐
Fainting……...	☐	☐	☐
Convulsions……	☐	☐	☐
Allergy……	☐	☐	☐
Skin problems…….	☐	☐	☐
Colds……...	☐	☐	☐
Tremors……..	☐	☐	☐
Loss of Balance……..	☐	☐	☐

Eyes, Ears, Nose, Throat	O	F	C
Asthma……...	☐	☐	☐
Sinus trouble……..	☐	☐	☐
Tonsillitis……...	☐	☐	☐
Sore throat…….	☐	☐	☐
Earache……..	☐	☐	☐
Deafness…….. .	☐	☐	☐

STRESS SYMPTOMS	O	F	C
Headache…….	☐	☐	☐
Migraines…….	☐	☐	☐
Dizziness…….	☐	☐	☐
Numbness or pins & needles in arms/hands, legs/feet……..	☐	☐	☐
Ringing in ears……	☐	☐	☐
Blurring of vision……	☐	☐	☐
Loss of sleep……	☐	☐	☐
Loss of concentration……..	☐	☐	☐
Loss of memory……...	☐	☐	☐
Irritable/nervousness……...	☐	☐	☐
Depression……..	☐	☐	☐
Decreased energy/fatigue……	☐	☐	☐
Tension……	☐	☐	☐

RESPIRATORY	O	F	C
Chronic cough……	☐	☐	☐
Spitting up phlegm/blood……	☐	☐	☐
Chest pain……	☐	☐	☐
Difficulty breathing…….	☐	☐	☐

GASTROINTESTINAL	O	F	C
Indigestion……...	☐	☐	☐
Gas pains…….	☐	☐	☐
Nausea or vomiting…….	☐	☐	☐
Stomach pains…….	☐	☐	☐
Constipation…….	☐	☐	☐
Heartburn…….	☐	☐	☐
Diarrhea……...	☐	☐	☐
Colon trouble……...	☐	☐	☐
Liver trouble…….	☐	☐	☐
Bladder trouble…….	☐	☐	☐
Kidney trouble…….	☐	☐	☐
Blood stools…….	☐	☐	☐

URINARY	O	F	C
Painful urination……...	☐	☐	☐
Waking at night to urinate...	☐	☐	☐
Increased urination……...	☐	☐	☐
Blood in urine……..	☐	☐	☐

FEMALES ONLY	O	F	C
Painful menstruation……	☐	☐	☐
Irregular periods……..	☐	☐	☐
Passed menopause……...	☐	☐	☐
Menopausal symptoms……	☐	☐	☐
Birth control pill……**yes** ☐ **no** ☐			

Date of last menstruation:
_____

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