HEALTH MATTERS CHIROPRACTIC CENTRE

Defining health to enhance life. Dr. Mark Renzoni and Dr. Michael Lehr
Chiropractic, Registered Massage Therapy & Acupuncture

3175 Rutherford Road, Suite 57, Vaughan, Ontario L4K 5Y6
Tel: (905) 532 0410 **Fax**: (905) 532 0413 www.EnhanceLife.ca

PATIENT INTAKE FORM

Patient #: _____
Date:_____

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law. You will be asked to provide written authorization for release of any information

Personal History

Name: _____
First **Initial** **Last**

Address: _____
Street **Apt.** **City** **Province** **Postal Code**

Home phone: (____)_____ Cell phone: (____)_____ Bus. phone: (____)_____X__

e-mail _____Would you like to receive newsletters and updates via email: □ Y □ N

Birth date: (dd/mm/yyyy)_____ Age:_____ Sex: □ M □ F Chiro/Massage experience: □ Y □ N

Business/Employer_____ Extended Health Coverage: □ Y □ N AMT: _____

Type of Work: _____ **Circle one**: Married Single Divorced Separated Other

Name and number of emergency contact: _____

Referred to us by?: _____

Current Health Condition:

What is your primary complaint?: _____

What is your general health status?: _____

Other Health Professional seen for this condition: □Y □ N Who? _____

Type of Treatment: _____ Results: _____

When did this condition begin?_____ Has the condition occurred before: □ Y □ N

Is condition: □ Job-related □ Auto-related □ Home injury □ Fall □ Other _____

Date of accident: (dd/mm/yyyy) _____ MVA: □ Y □ N WSIB: □ Y □ N Claim #:_____

What aggravates your condition? □ Sitting □ Standing □ Bending □ Lifting □ Walking
□ Lying Down □ Cold □ Dampness □ Other_____

What relieves your condition? □ Bed rest □ Ice □ Heat □ Massage □ Medication □ Other_____

Is your condition getting: □ Worse □ Constant □ Comes and Goes □ Better

Character of the pain: □ Sharp □ Dull □ Ache □ Pins and Needles □ Numb
□ Burning □ Constant □ Intermittent □ Other_____

Please describe how it feels when this problem is at its worst. _____

Please place an X on the grade indicating your severity of pain.

No pain The Worst Pain you can Imagine

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General Symptoms
- □ Headaches

type: _____
- □ Loss of consciousness
- □ Blackouts
- □ Fever
- □ Sweats
- □ Fainting
- □ Dizziness
- □ Clumsiness
- □ Convulsions
- □ Loss of sleep
- □ Numbness, pain or tingling
- □ Nervousness
- □ Loss of weight

Respiratory
- □ Chronic cough
- □ Spitting up phlegm
- □ Spitting up blood
- □ Chest pain
- □ Difficulty breathing

Cardiovascular
- □ High blood pressure
- □ Low blood pressure
- □ Poor circulation
- □ Heart disease
- □ Angina
- □ Stroke
- □ Varicose veins
- □ Pain over heart
- □ Hardening of arteries
- □ Swelling of ankles
- □ Bleeding disorders

Infections
- □ Herpes
- □ Hepatitis
- □ Plantar warts
- □ TB
- □ HIV, AIDS
- □ Other: _____

Skin
- □ Skin conditions

type:_____
- □ Bruise easily
- □ Rashes, itching
- □ Dryness
- □ Boils
- □ Hives

Muscles and Joints
- □ stiff neck
- □ back ache
- □ swollen joints
- □ Painful tailbone
- □ Foot trouble
- □ Shoulder pain
- □ Arm/Forearm pain
- □ Elbow pain
- □ Wrist pain
- □ Hand pain
- □ Arthritis

affected areas _____
- □ Jaw (TMJ) pain or clicking
- □ Weakness or loss of strength

E.E.N.T.
- □ Blurred vision
- □ Failing vision
- □ Crossed eyes
- □ Double vision
- □ Eye pain
- □ Deafness
- □ Earache
- □ Ringing, buzzing, any noise in ears
- □ Asthma
- □ Frequent Colds
- □ Sinus infection
- □ Enlarged glands
- □ Enlarged thyroid
- □ Slurred or other speech problems
- □ Difficulty swallowing
- □ Dental problems

Previous Chiropractor/Massage Therapist
Name: _____
Phone: _____
Date of last visit:_____

Medical Doctor
Name: _____
Phone: _____
Date of last visit:_____

X-rays in last 6 months: □ Y □ N
Region(s)_____
Have you ever had any fractures? □ Y □ N
Region(s)_____

Current Medications

Name	For what condition?
_____	_____
_____	_____
_____	_____
_____	_____

Genitourinary
- □ trouble urinating
- □ Blood in urine
- □ Kidney infection
- □ Bed wetting
- □ Prostate trouble
- □ Sexual dysfunction

Gastrointestinal
- □ Indigestion
- □ Excessive hunger
- □ Belching or gas
- □ Nausea
- □ Vomiting (blood?)
- □ Pain over stomach
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids (piles)
- □ Jaundice
- □ Gall bladder trouble
- □ Intestinal worms
- □ Ulcer
- □ Diabetes
- □ Poor appetite

Women
- □ Painful
- □ Excessive Flow
- □ Hot Flashes
- □ Irregular cycle
- □ Cramps or backache
- □ Vaginal discharge
- □ swollen breasts
- □ Lumps in breasts

Have you ever been on birth control? □ Y □ N
Are you currently taking the birth control pill? □ Y □ N
# of pregnancies:_____
# of children: _____
Are you Pregnant? □ Y □ N
Due date:_____

Lifestyle Stress Level
- □ High
- □ Moderate
- □ Very Little

Have you ever been in a car accident?
□ Y □ N When:_____

Have you ever been hospitalized?
□ Y □ N Reason:_____

Have you ever had surgery?
□ Y □ N Type:_____

Have you ever been diagnosed with Cancer?
□ Y □ N Type:_____

Are you currently a smoker?
□ Y □ N

Have you ever smoked in the past?
□ Y □ N

Do you have a regular exercise program?
□ Y □ N

Other medical conditions? _____
Of special note: pins, wires, artificial joints or limbs

Updated (date)					
Signature					

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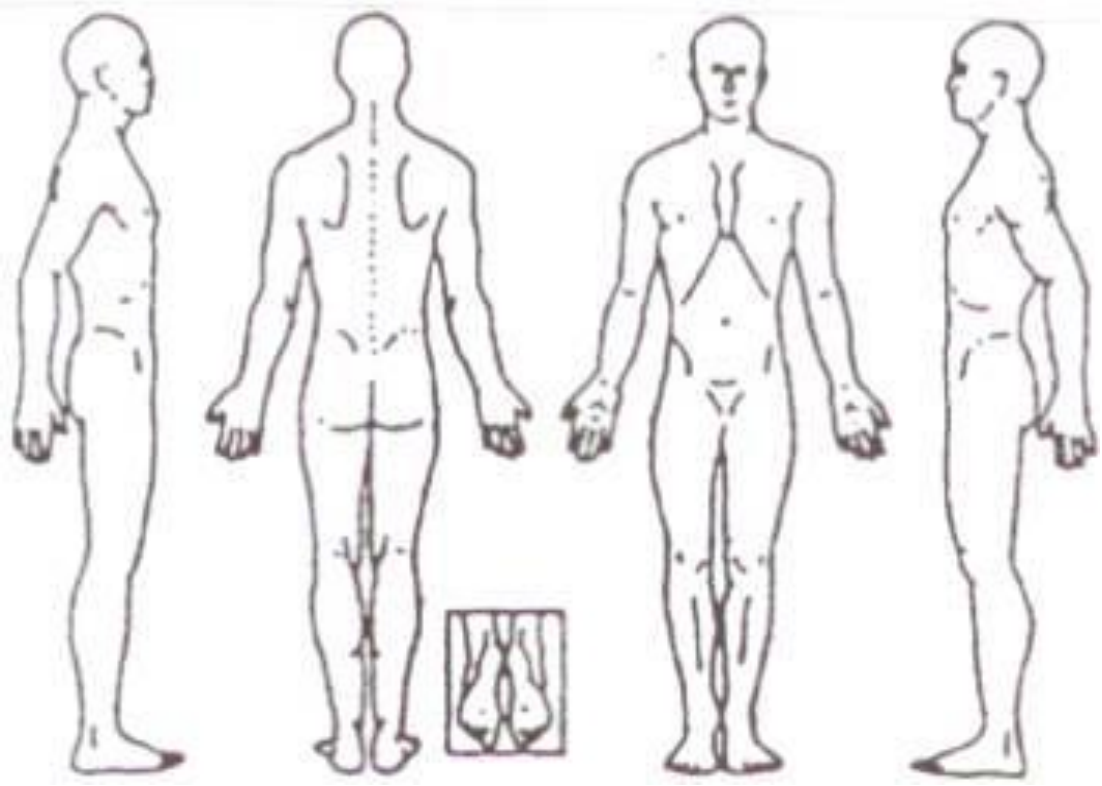
Patient Name:_____ **Patient #:** _____
Date:_____

SYMPTOM DIAGRAM



In the diagram provided, please mark the areas on your body, which you feel represent the pain(s) or sensation(s) you are experiencing. Please include all area. You may use the symbols provided below.

Symbols:				
	Numbness	nnnnnn	Pins and Needles	::::::::::
	Burning	xxxxxx	Stabbing & Sharp	ssssssss
	Dull & Aching	>>>>>	Stiff & Tight	++++++