HEARTLAKE CHIROPRACTIC & SPINAL DECOMPRESSION CENTRE

Welcome to our Clinic. Please complete the following Health Information

Date:	**Name:**	**Gender: F M**
Address:	**City:**	**Postal Code:**
Phone: (h)	**(c)**	**(w)**
Date of Birth (mm/dd/yyyy):	**Occupation:**	
Email Address:	**How did you hear about us?**	
Family Doctor:	**Phone:**	
Emergency Contact:	**Phone:**	

Are you, or have your experienced any of the following symptoms?

Check all that apply

- ☐ Pain / Discomfort
- ☐ Swelling
- ☐ Spasm
- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Weakness
- ☐ Headaches
- ☐ Dizziness /Fainting
- ☐ Nausea / Fever
- ☐ Fatigue
- ☐ Digestive problems
- ☐ Urination problems
- ☐ Bowel problems
- ☐ Sexual Dysfunction
- ☐ Numbness in buttocks
- ☐ Anxiety / panic attacks
- ☐ Depression
- ☐ Insomnia
- ☐ Acid reflux / Ulcers
- ☐ Blood in urine
- ☐ Weight loss / gain
- ☐ Night sweats
- ☐ Allergies

Details:

Do you, or have you ever had?

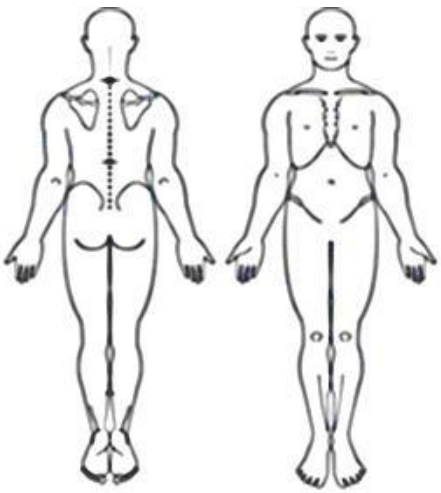
Check all that apply

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Spinal Infection
- ☐ Diabetes
- ☐ Cancer
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Heart Disease / Pacemaker
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Stroke / TIA / Aneurysm
- ☐ Blood Clots
- ☐ Abdominal Aortic Aneurysm
- ☐ Angina
- ☐ Respiratory Disease
- ☐ Asthma / Chronic Bronchitis
- ☐ Thyroid disease / problems
- ☐ Kidney disease / problems
- ☐ Liver disease / problems
- ☐ Skin problems
- ☐ Psychological disorder
- ☐ Fibromyalgia / Chronic Fatigue

Details:

Where is your pain?

Indicate the location of your pain or symptoms on the diagrams.



How severe is your pain?

Circle the appropriate pain level and description.

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild		Moderate			Severe			Excruciating

What do you feel caused your problem?	☐ Injury / Trauma ☐ Sports related ☐ Work related ☐ Stress related ☐ Unknown ***Describe:*** **Is this a reported work related injury (WSIB)?* ☐ No ☐ Yes **Is this complaint the result of a motor vehicle accident (MVA)?* ☐ No ☐ Yes **Describe what happened:**		
When did your symptoms begin?	☐ Recent onset. How many (days / weeks): ☐ Chronic problem. How many (months / years): ☐ This is the first time the problem has occurred. ☐ Recurring problem. How many episodes:	**How frequent are your symptoms?**	☐ Constant (never stops or changes) ☐ Daily (off and on) ☐ Intermittently (weekly / monthly) ☐ Only when aggravated ☐ Occasionally without provocation.
Are your symptoms improving?	☐ No change / improvement ☐ Better (on its own / with time) ☐ Better (with treatment / exercise)	**Is the problem getting worse?**	☐ Worse (on its own / with time) ☐ Worse (with treatment / exercise) ☐ Worse with additional symptoms
What relieves your symptoms?	☐ Any Activity or Movement ☐ Rest (sitting or lying) ☐ Stretching ☐ Treatment (what type?) ☐ Heat / Cold / Epsom bath ☐ Medication ☐ Other:	**What aggravates your symptoms?**	☐ Any Activity or Movement ☐ Rest (sitting or lying) ☐ Desk work / Computer work ☐ Driving or Sitting ☐ Walking or Standing or Stairs ☐ Bending or Twisting or Lifting ☐ Other:
What treatment have you had? *Check all that apply*	☐ Chiropractic ☐ Massage Therapy ☐ Physiotherapy ☐ Medical Consult only ☐ Medication ☐ Surgery ☐ Nerve block / injection ☐ Chinese Med / Acupuncture ☐ Naturopathic / Osteopathic ☐ Other:	**What tests have you had?** *Check all that apply*	☐ Blood work ☐ X-rays / Ultrasound ☐ ECG / EMG / NCT ☐ CT Scan ☐ MRI ☐ Bone Density When and Where?

Medical History: *Please complete as thoroughly as possible.*			
Surgeries	☐ None	☐ Yes	List:
Fractures / Injuries	☐ None	☐ Yes	List:
Accidents / Falls	☐ None	☐ Yes	List:
Medications			