26 Peel Street Lindsay, Ontario K9V 3L8
(705) 324-2556 (888) 855-9688 fax

Confidential Patient Information Form

We are pleased that you have chosen to consult us regarding your health. In order to help us evaluate your condition thoroughly, please complete the following form. This information is important so we ask that you be accurate. Please ask for assistance if needed.

Date: ________________________________

Name: ____ Referred By: _______________________________

Address: ______________________________________ City: _____________________ Postal Code: _____________

May we mail correspondence to the above address? ☐Y ☐N

Home Phone: _____________________Work Phone: _____________________Cell Phone: _____________________

Preferred phone number to leave messages: ☐*home* ☐*work* ☐*cell*

E-mail: ____________________________________ *May we contact you at this email address?* ☐Y ☐N

Birthdate: __________________________________ Age:_____ Gender: ☐M ☐F

Occupation:________________________________ Employer: ______________________________________

Type of Work:______________________________ Hours Work/Study per week : _______________

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Common Law

Spouse/Partner's Name: ________________Children: Names/Ages: ____

Extended Health Care Insurance: Company: ______________________________________

Family Physician - Name: _______________________________ Address: _________________________________

Phone Number: _________________________

Previous Chiropractic Care – Have you been to a chiropractor before? ☐Y ☐N

If Yes, Chiropractor's name: ______________________ City: __________________ Reason for attending: __________________

Previous Massage Therapy – Have you been to a registered massage therapist before? ☐Y ☐N

If Yes, RMT's name: ______________________ City: __________________ Reason for attending: __________________

Approximate date last seen: ☐Chiro or ☐RMT_______________________ Were X-rays taken: ☐Y ☐N

May we send a thank you to the person who referred you to our office for care? ☐Y ☐N

Your Health Profile

As a wellness centre, we focus on your ability to be healthy. Our goals are to initially address any issues that brought you to this office, and then to offer you the opportunity of improved health and improved quality of life in the future. On a daily basis we all experience physical, chemical and psychological stresses that can accumulate and lead to a serious loss of health potential. Most times these effects are gradual and may not even be felt until they become serious. Answering the following questions will provide us with a profile of the specific stresses in your life, past and present. This will allow us to better assess the challenges to your full health potential. Patients accepted for care in our office will be provided with an individualized treatment care plan, with regular progress exams as necessary to assess changes.

Reason for attending our office: ____

Location of pain? ____

How long have you had this condition? ____

Have you had this (or similar) conditions in the past? ____

Pain aggravated by? ____

Pain relieved by? ____

Is the condition getting: ☐Better? ☐Worse? ☐Same?

Is the condition: ☐Constant? ☐Frequent? ☐Infrequent? Details:

____

How is this negatively affecting:

Your Family Life? ____________________ Your Career? ____________________

Your Social Life? ____________________ Your Physical Health & Recreation? ____________________

Your Emotional Life? ____________________ Your Energy/Concentration? ____________________

Your Sleep Quality & Quantity? ____________________

Other treatments tried (eg. Massage, Acupuncture, Physical Therapy, Medical): ____________________

How long has it been since you really felt good? ____

List any medications you are taking: ____

List any surgeries (dates): ____

Allergies: ____

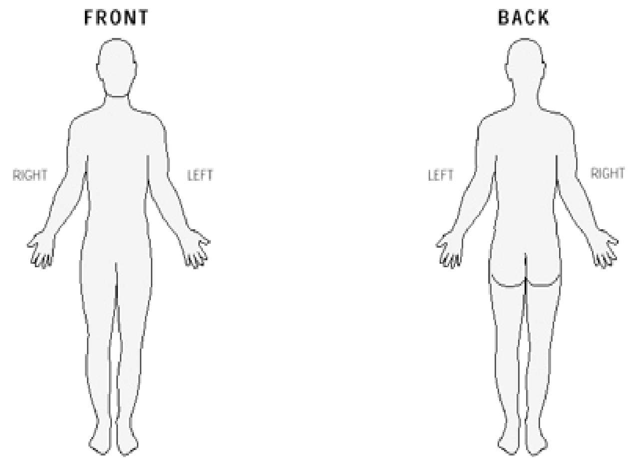
Pregnancies? ____

Have you had any diagnostic studies? ☐X-ray ☐CT-Scan ☐MRI ☐Lab Work ☐EMG

☐Other: ____________________

Characteristics of the pain.

Using the key below, mark the areas of your body where you feel the described sensations. Use the appropriate symbols. Circle the area if you are unable to describe the sensation. Also mark areas of shooting or radiating symptoms. Include all affected areas:



XXX = Sharp Pain
TTT = Tense/Tight
BBB = Burning
AAA = Ache
+++ = Pins and Needles
/ / / = Numbness
>>> = Radiates
OOO = Other (describe)

Please circle the number corresponding to the severity of your pain:

1 2 3 4 5 6 7 8 9 10

MILD SEVERE

Please check anything you are currently experiencing or have experienced in the past.
Please add anything not mentioned in the lists.

HEAD
___ headaches
___ trauma
___ vertigo
___ vision problems
___ earache
___ jaw pain
___ sinusitis
other:___________________________

NEUROLOGICAL
___ fainting spells
___ blackouts
___ seizures
___ weakness
___ tingling
___ paralysis
other:___________________________

DIGESTIVE / URO-GENITAL
___ poor appetite
___ constipation
___ diarrhea
___ vomiting
___ nausea
___ ulcers
___ difficult digestion
___ liver
___ gallbladder
___ kidney
___ diabetes (onset:____________)
other:___________________________

CARDIOVASCULAR
___ leg cramps
___ varicose veins
___ poor circulation
___ phlebitis
___ aneurysm(s)
___ angina
___ atherosclerosis (hardening of arteries)
___ heart attack
___ stroke
___ high blood pressure
___ low blood pressure
___ heart disease
___ heart murmur
___ pacemaker
___ chronic congestive heart failure
other:___________________________

WOMEN
___ menstrual problems
___ pregnancy/due date: ______________
___ # of children _________
___ history of miscarriage
___ menopause
___ hysterectomy
other:___________________________

MUSCLES/JOINTS
___ osteoarthritis
___ rheumatoid arthritis
___ fibromyalgia
other:___________________________

RESPIRATORY
___ chronic coughing
___ coughing phlegm
___ asthma
___ bronchitis
___ emphysema
___ shortness of breath
___ smoking
other:___________________________

SKIN
___ itching
___ rash
___ bruise easily
___psoriasis
other:___________________________

OTHER CONDITIONS
___ frequent colds
___ insomnia
___ anxiety
___ depression
___ fatigue
___ epilepsy
___ forgetfulness
___ hepatitis
___ HIV
___ tuberculosis
___ pins/prosthesis
___ thyroid imbalance
other:___________________________

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Many health problems are the result of hereditary weaknesses, thus information about your family members will give us a better picture of your total health. Please mention below any health conditions or concerns you may have about your:

Children: ____

Spouse: ____

Mother: ____

Father: ____

Brother(s): ____

Sister(s): ____

Others: ____

Patient Goals

Please check the phrase that most accurately represents your main reason(s) for coming to Equilibrium Chiropractic and Wellness Centre:

☐ Symptom relief – Get rid of the pain and/or discomfort

☐ Corrective/Functional Care – Get rid of the pain and/or discomfort, but also address any underlying factors that may contribute to my symptoms, or may cause future problems such as weakness, poor posture, chronic tightness, chronic spinal dysfunction.

☐ Performance/Wellness Care – Keep me performing at my best at work, home and for my recreational activities.

The answers to the questions and the information I have provided is accurate to the best of my recollection, and I understand and agree that the doctors and staff of Equilibrium Chiropractic and Wellness Centre will use this information to provide evaluation, recommendations and treatment. All information on these forms is completely confidential.

Signed: ______________________________ Date: ____________________