



KAWARTHA THERAPEUTIC
CENTRE

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CONFIDENTIAL PATIENT INFORMATION FORM

Please take a few moments to complete this form as accurately as possible. Your answers will help us determine if we are able help you (and therefore, if we can accept your case). If we believe that your condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with the form, please do not hesitate to ask our receptionists.

Name: _____ Date: _____
 Address: _____ City: _____ Postal Code: _____
 Home Tel: () _____ Cell Tel: () _____ Work Tel: _____
 Date of Birth (D/M/Y): _____ Age: _____ Gender: male female
 E-mail address: _____ (100 % confidential - for clinic newsletter/appointment reminders)
 Family Status: single married widowed divorced # of children _____ Ages: _____
 Occupation: _____ Employer: _____
 Extended Health Care Company: _____
 Medical Doctor's name: _____
 Approximate date of last medical appointment: _____ Reason for visit: _____
 How did you hear about our office? A friend: if so, who? _____
 Medical Doctor Sign Ad Website Other: _____
 Have you ever been to a chiropractor before? No Yes, if Yes, Chiropractor's Name: _____
 Approximate date of last chiropractic appointment: _____ Reason for visit: _____

DESCRIPTION OF CURRENT INJURY/PAIN

Please describe your major complaint(s) including area(s) of the body affected, and your best reasoning as to what caused it: _____

When (what date or how long ago) did you first notice the problem? _____

Please rate the severity of your complaint by checking one box on the below scale.

No Problem	1	2	3	4	5	6	7	8	9	10	Severe Problem
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(At best/at worst) _____

Is the complaint constant, frequent or infrequent? _____

When do you notice your complaint the most? _____

What aggravates your complaint? Sitting Standing Bending Lifting

Walking Bed Rest Weather Changes Other _____

What relieves your complaint? Ice Heat Massage Stretches Bed Rest Walking

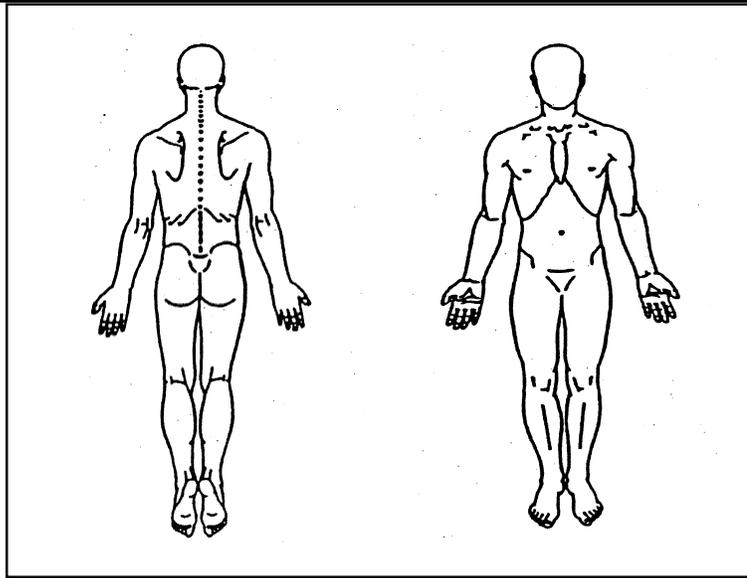
Medications Other _____

Is it getting: Worse Better Constant Comes and Goes

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 & Needles
- /// = Numbness
- >->-> = Radiates
- OOO = Other (describe)



What treatments have you had for this problem? Chiropractic Physical Therapy Massage Medical Treatment
 Acupuncture Other Procedures _____

Have you ever had this or a similar problem before? _____

Do you have any other (secondary) complaints? Please Describe: _____

Have you had any diagnostic studies? X-rays CT scans MRI scans Lab work EMG's Other _____

How does this problem affect your life with respect to:

Your ability to work? _____

Your ability to enjoy family/social time/activities/sports? _____

GENERAL HEALTH

Compared to 5 years ago, would you say your overall health is: better staying the same worse

Overall Stress Levels: high med-high medium med-low low

Medications you currently take: Painkillers Muscle Relaxants Anti-inflammatory Heart Meds Insulin

For Indigestion For Depression For Anxiety For Asthma Blood Pressure HRT Other _____

Natural supplements you currently take: Multivitamin Vitamin C B-complex vitamins Calcium Omega3/6/9

Prenatal vitamin Folic Acid Glucosamine Homeopathic Naturopathic remedies Other _____

What is your personal satisfaction with your diet? Highly satisfied Satisfied Dissatisfied Highly Dissatisfied

Do you have a regular exercise program? No Yes What type, and how often? _____

Do you wear orthotics? Yes No If yes – approximately how old are they? _____

Do you use tobacco? No Yes - Amount: _____ In the past - what year did you quit? _____

Do you use alcohol? No Yes – Occasionally Yes – Regularly

Do you suffer from any other health conditions? No Yes (please list) _____

PAST HEALTH HISTORY:

Please describe any hospitalizations or surgical operations and state the approximate dates: _____

Please describe any previous traumas (accidents, sports injuries, work injuries, etc) and approximate dates: _____

The follow is a list of conditions, which may seem unrelated to your current complaint. However, we would like to assess your full health picture, and some of these conditions can also be affected by your overall courses of care. Please check the appropriate box for any of the following symptoms which you have now or have experienced previously. **C= currently** **P= previously**

<p>C P</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of consciousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Blackouts/fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> <input type="checkbox"/> Clumsiness</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of balance</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness in arm/hand</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness in leg/foot</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> <input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Recent weight gain</p> <p><input type="checkbox"/> <input type="checkbox"/> Recent weight loss</p> <p>SKIN</p> <p>C P</p> <p><input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> Skin rash</p> <p><input type="checkbox"/> <input type="checkbox"/> Bruises easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> <input type="checkbox"/> Varicose veins</p>	<p>MUSCLE & JOINT</p> <p>C P</p> <p><input type="checkbox"/> <input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Foot trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in the joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> <input type="checkbox"/> Jaw pain/TMJ</p> <p>CARDIOVASCULAR</p> <p>C P</p> <p><input type="checkbox"/> <input type="checkbox"/> Aneurysm</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain over the heart</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle swelling</p>	<p>EYES, EARS, NOSE & THROAT</p> <p>C P</p> <p><input type="checkbox"/> <input type="checkbox"/> Wear glasses/contacts</p> <p><input type="checkbox"/> <input type="checkbox"/> Blurred/double vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> <input type="checkbox"/> Ear aches</p> <p><input type="checkbox"/> <input type="checkbox"/> Ringing or buzzing in ears</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Enlarged glands</p> <p><input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing</p> <p>GENITO-URINARY</p> <p>C P</p> <p><input type="checkbox"/> <input type="checkbox"/> Bed wetting</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss control urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney infection</p> <p><input type="checkbox"/> <input type="checkbox"/> Prostate trouble</p>	<p>LUNG & BREATHING</p> <p>C P</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> <input type="checkbox"/> Spitting blood</p> <p>GASTROINTESTINAL</p> <p>C P</p> <p><input type="checkbox"/> <input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> <input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting blood</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain over stomach</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> <input type="checkbox"/> Jaundice</p> <p>WOMEN ONLY</p> <p>C P</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful menstruation</p> <p><input type="checkbox"/> <input type="checkbox"/> PMS</p> <p><input type="checkbox"/> Pregnant Due date _____</p> <p># of pregnancies _____</p> <p># of children _____</p> <p>Menopausal? Y / N</p>
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FAMILY HEALTH HISTORY

Is there any current or past history of medical conditions, diseases, or illnesses in your family? What medical problems do your parents or siblings have? Please list relationship and problem: (ex: Peter – Father - diabetes)

PLEASE CHECK THE PHRASE THAT MOST REPRESENTS YOUR REASONS FOR CARE:

- Symptom relief - i.e. get rid of the pain!
- Corrective/Functional Care - i.e. get rid of the pain, but also address any underlying factors that may contribute to my symptoms, or may cause future problems. ex. weak muscles, chronic spinal dysfunction, poor posture, chronic tightness, etc.
- Performance/Wellness Care - i.e. I acknowledge that there are many causes of daily repetitive physical stress to my body - keep me performing my best – at home, at work, and/or at play.

CORRESPONDANCE WITH YOUR PHYSICIAN:

Would you like me to send your physician or other health care provider a report detailing my assessment findings and plan of management? Yes No At your discretion