ROCKWAY CHIROPRACTIC CLINIC

625 King Street East - Unit 1B, Kitchener, Ontario N2G 4V4 Tel: (519) 744-4745 Fax: (519) 744-7120

To help us serve you better, please take the next few minutes to answer the following questions in order to ensure that our records of your health history are accurate and complete. **PLEASE PRINT**

Name: _____ Today's Date: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ E-Mail Address: _____

Telephone (Home): _____ (Cell): _____ (Work): _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Marital Status (circle): S M C.L. D W No. of Children: _____ Occupation: _____

Medical Doctor: _____ City: _____ Last Appointment: _____

Previous Chiropractor: _____ City: _____ Last Appt.: _____

How did you find out about our clinic? _____

Do you have Extended Health Benefits? ❒ Yes ❒ No *If Yes*, with what company? _____

What is the purpose of your appointment today?

❒ No Specific Problem - I'm wanting a Spinal Screening & Wellness Care → ***please skip ahead to page 3***

Is your visit today due to a ***Workplace Injury*** *(WSIB Claim)* or ***Motor Vehicle Accident*** *(MVA)*?

❒ WSIB ❒ MVA Accident Date? _____

(Please request our WSIB or MVA form if you're claiming for injuries)

What is your main complaint? _____

How long have you had this problem? _____

What do you feel caused this problem? _____

Has this problem ever occurred before? ❒ Yes ❒ No *If Yes*, when? _____

Have you consulted with any other health care practitioner for this problem? ❒ Yes ❒ No

If Yes, with whom did you consult? _____

What was their assessment of your condition? _____

What type of treatment did you receive? _____

Did it help? ❒ Yes ❒ No Were any x-rays taken or other imaging studies performed? ❒ Yes ❒ No

The following questions are related to your main complaint.

When do you experience this problem? ❒ All the time ❒ Comes & Goes frequently ❒ Infrequent

How often? *(i.e. 1x/day, 1x/month etc.)* _____ How long does it last? *(i.e. minutes/hours/days)* _____

In general, your problem is… ❒ Getting better ❒ Getting worse ❒ Not changing

On a scale of 0-10, how would you rate your pain? *(0 = no pain, 10 = worst pain ever)* _____

Describe what you feel: *(i.e. sharp pain, dull ache, burning, pins & needles etc.)* _____

Do you experience any numbness, weakness or headaches with your complaint? ❒ Yes ❒ No

If Yes, please describe: _____

Do you have any radiating pain? *(i.e. down your arm or leg)* ❒ Yes ❒ No *If Yes*, where? _____

Is coughing, sneezing or straining painful? ❒ Yes ❒ No Do you have any pain at night? ❒ Yes ❒ No

What activities or positions aggravate your problem? _____

What makes you feel better? _____

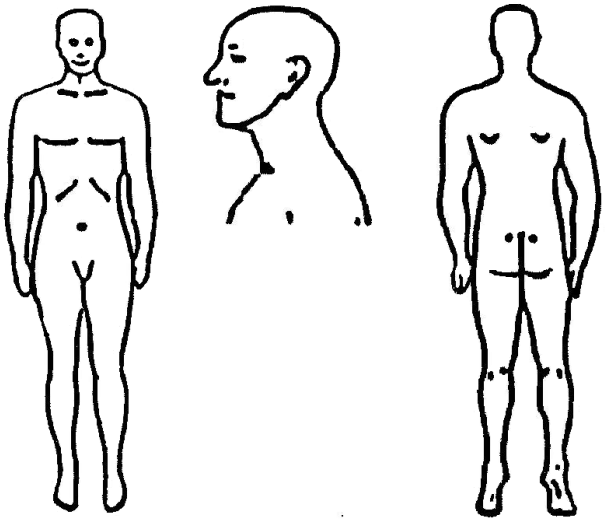
How does this problem affect your daily activities? _____

Do you have a history of any of the following?

- ❒ Osteoporosis
- ❒ Stroke
- ❒ Aneurysm
- ❒ Fibromyalgia
- ❒ Chronic Fatigue
- ❒ Sudden Unexplained Weight Loss

Please mark the areas on this body where you feel your pain or unusual sensations.
Use the appropriate symbols and include all affected areas.

Numbness	•••••
Sharpness	XXXX
Aching	OOOO
Burning	//////////
Prickling	******



Other Comments? _____

_____

The following questions are related to the general state of your health.

Present Illness/Conditions:

❒ AIDS	❒ Diabetes	❒ Low Blood Pressure	❒ Spinal Disc Disease
❒ Allergies	❒ Dislocated Joints	❒ Mental/Emotional Difficulty	❒ Thyroid Trouble
❒ Anemia	❒ Diverticulitis	❒ Multiple Sclerosis	❒ Tuberculosis
❒ Arthritis	❒ Hay Fever	❒ Pacemaker	❒ Ulcer
❒ Asthma	❒ Heart Problems	❒ Prostate Trouble	❒ Polio
❒ Bone Fracture	❒ High Blood Pressure	❒ Rheumatic Fever	❒ STDs
❒ Cancer _____	❒ HIV/ARC	❒ Scoliosis	❒ Epilepsy
❒ Cirrhosis/Hepatitis	❒ Kidney Trouble	❒ Sinus Trouble	❒ Sleep Disorder

Other: _____

Medication Use? _____

Are you pregnant? ❒ Yes ❒ No ❒ Maybe Due Date: _____

Have you had any surgery in the last 5 years? ❒ Yes ❒ No *If Yes*, last surgery date? _____

Reason for surgery? _____

Did you require medical attention or hospitalization as a child? ❒ Yes ❒ No

If Yes, please describe: _____

Have you ever been in an auto accident? ❒ Yes ❒ No *If Yes*, when? _____

If Yes, please describe any injuries and subsequent treatment: _____

_____

Have you ever used any orthopedic braces or supports? *(i.e. back support, orthotics etc)* ❒ Yes ❒ No

If Yes, please list: _____

What type of bed do you sleep on? _____ Usual sleeping position? _____

Social History:

Alcohol? ❒ Yes ❒ No	Cigarettes? ❒ Yes ❒ No	Caffeine? ❒ Yes ❒ No	Exercise? ❒ Yes ❒ No
Drinks per week? _____	Packs per day? _____	Drinks per day? _____	Light / Moderate / Heavy

Family History of Illness:

❒ AIDS	❒ Diabetes	❒ Mental/Emotional Difficulty	❒ Tuberculosis
❒ Allergies	❒ Dislocated Joints	❒ Multiple Sclerosis	❒ Ulcer
❒ Anemia	❒ Diverticulitis	❒ Prostate Trouble	❒ Polio
❒ Arthritis	❒ Heart Problems	❒ Rheumatic Fever	❒ STDs
❒ Asthma	❒ High Blood Pressure	❒ Scoliosis	❒ Epilepsy
❒ Bone Fracture	❒ HIV/ARC	❒ Sinus Trouble	
❒ Cancer _____	❒ Kidney Trouble	❒ Spinal Disc Disease	
❒ Cirrhosis/Hepatitis	❒ Low Blood Pressure	❒ Thyroid Trouble	

Other: _____