



**Please complete this form as fully and carefully as possible.**

Your answers help us determine the true nature of your complaint and how best we may help you.

Name: \_\_\_\_\_ Gender: M / F Date of Birth: \_\_\_\_\_ (dd/mm/yyyy)  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
 Your occupation: \_\_\_\_\_ What do you do mostly? (sit / stand / etc.) \_\_\_\_\_  
 Marital status: S / M / D / W Do you have any children? Y / N Ages: \_\_\_\_\_  
 Family Doctor Name & Address: \_\_\_\_\_  
 Do we have permission to communicate with your GP if required? Y / N  
 Date of Last Physical Exam: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Have you ever been to a chiropractor before? Y / N Name of chiropractor: \_\_\_\_\_  
 For what condition: \_\_\_\_\_ How long ago: \_\_\_\_\_

WAS THIS AN INJURY THAT OCCURRED AT WORK? Y / N Was it reported? Y / N WSIB# \_\_\_\_\_  
 WAS THIS AN INJURY AS A RESULT OF A CAR ACCIDENT? Y / N Is there a claim pending? Y / N

Please list any significant illnesses or limitations: \_\_\_\_\_  
 List any medications or supplements: \_\_\_\_\_  
 Do you smoke? Y / N If yes, how much? \_\_\_\_\_ For how long? \_\_\_\_\_  
 List any allergies \_\_\_\_\_  
 How would you rate your level of stress? low / med / high  
 Do you exercise regularly? Y / N What type of exercise? \_\_\_\_\_  
 Do you use any devices such as cervical pillows, orthotics, back supports, braces, etc.? Y / N  
 specify \_\_\_\_\_  
 Where do you carry your wallet or purse? over shoulder \_\_\_ back pocket \_\_\_ front pocket \_\_\_ L \_\_\_ R \_\_\_ backpack \_\_\_  
 What is your daily water intake? \_\_\_\_\_ 8 oz. glasses  
 What is your daily intake of caffeinated beverage or soft drink? \_\_\_\_\_ 8 oz. Glasses

**HEALTH HISTORY- please list**

Severe accidents/falls \_\_\_\_\_  
 Hospitalization \_\_\_\_\_  
 Surgery \_\_\_\_\_  
 Fractures \_\_\_\_\_  
 X-rays \_\_\_\_\_  
 Unusual weight change \_\_\_\_\_

**CHILDHOOD ILLNESS**

Chicken pox   
 Headaches   
 Measles   
 Mumps   
 Rubella   
 Rheumatic Fever   
 Whooping cough   
 Tuberculosis   
 Other \_\_\_\_\_

**FAMILY HISTORY (parents, siblings, etc.) please list**

Anemia \_\_\_\_\_  
 Arthritis \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Epilepsy \_\_\_\_\_  
 Headache/migraine \_\_\_\_\_  
 Heart Disease \_\_\_\_\_  
 Mental Illness \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Other \_\_\_\_\_

**DO YOU CURRENTLY EXPERIENCE? (Please circle)**

Chest pain      Cramps      Constipation      Diarrhea      Dizziness      Headache  
 Fainting      Excess Thirst      Fatigue      PMS      Heartburn /Gas      Numbness      Pain  
 Seizures      Spasms      Stiffness      Swelling      Unusual Bleeding      Vomiting      Weakness  
 Frequent Urination      Painful Urination

How did you hear about our clinic? sign outside \_\_\_ yellow pages \_\_\_ newspaper ad \_\_\_ other \_\_\_\_\_  
 webpage \_\_\_ friend / other client \_\_\_ Who? \_\_\_\_\_

If one of our clients sent you, may we acknowledge their referral? Y / N

**In Tune Chiropractic** adheres to federal privacy legislation. All information received is strictly confidential and for diagnostic purposes only.  
 If it is necessary to release or obtain any of your health information to further manage your case, your permission will be required.

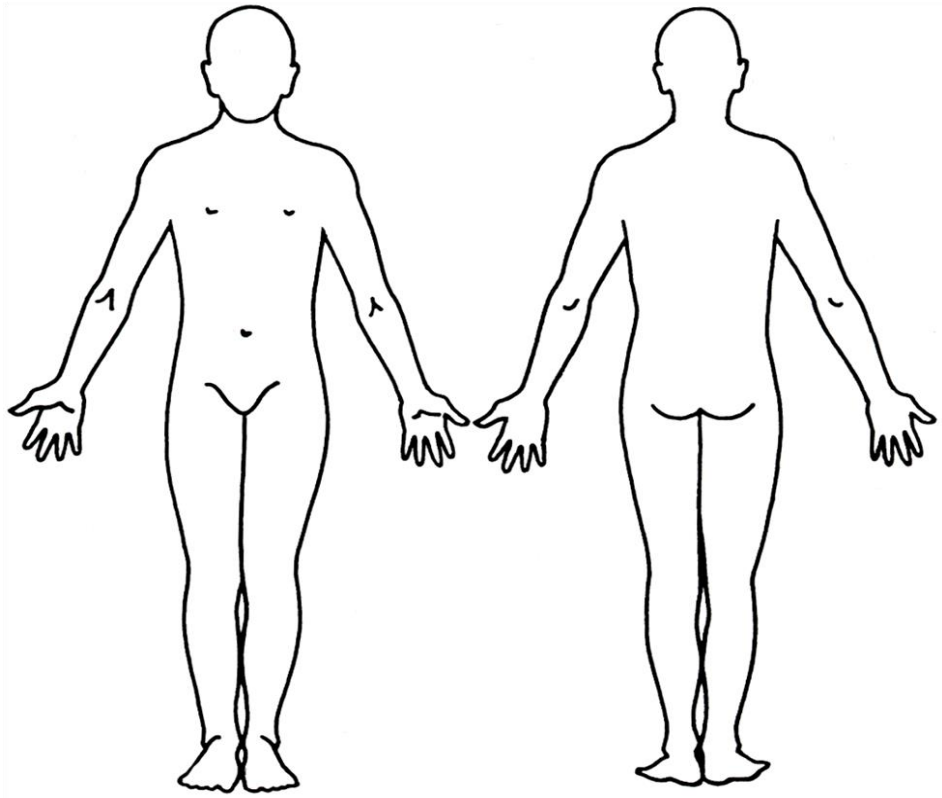
Patient signature \_\_\_\_\_ Date \_\_\_\_\_

In the diagrams provided below, please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas.

Use the symbols provided below.

**Symbols:**

- Numbness -----
- Burning xxxxxxxxxxxxxxxxx
- Dull and aching ++++++
- Pins and needles .....
- Stabbing and sharp ^^^^^^^
- Stiff and tight 22222222222222



Front

Back

On the line provided, please mark where your "pain status" is today

No Pain \_\_\_\_\_ Most Severe Pain