74 Daniel St. S Arnprior ON K7S 2L7 Dr. Trisha Gibson

in tune CHIROPRACTIC

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/ Other Date of Birth:_____ (dd/mm/yyyy)
Home Address:_____ City:_____ Postal Code:_____
Phone: (H)_____ (W)_____ (C)_____email:_____
Your occupation:_____ What do you do mostly? (sit / stand / etc.)_____
Marital Status: S / M / CL / 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

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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.

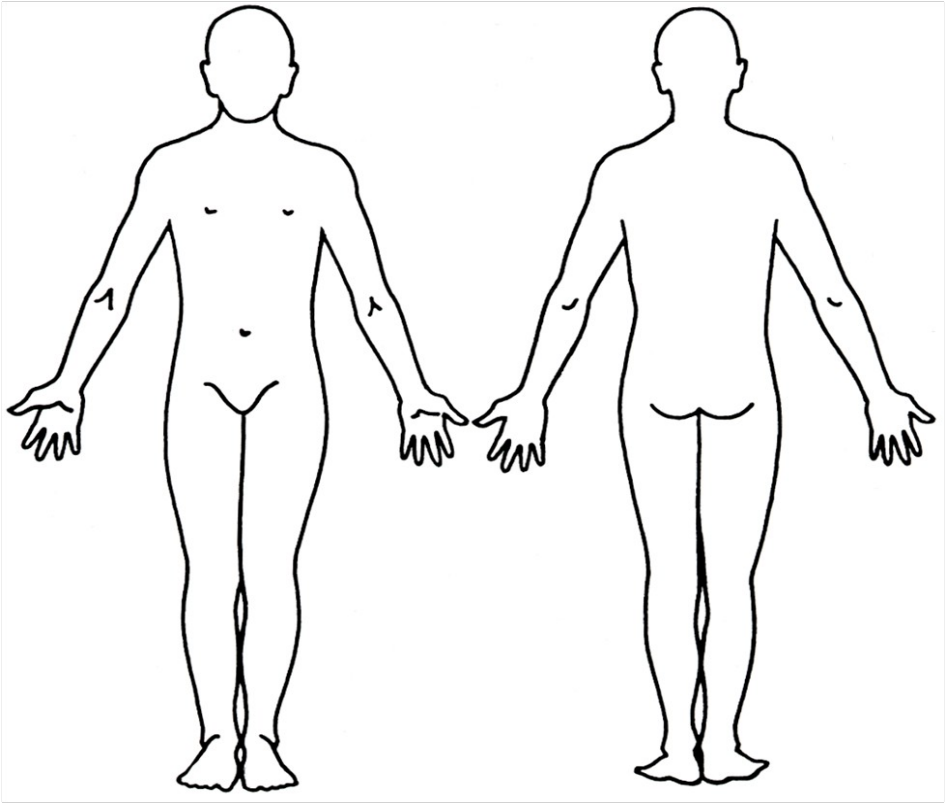
Patient signature _____ Date _____

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	xxxxxxxxxxxxxxx
Dull and aching	++++++++++++
Pins and needles	.....
Stabbing and sharp	^^^^^^^^^^^^
Stiff and tight	222222222222222



Front Back

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

No Pain _____ Most Severe Pain