[Broddick] Chiropractic and Acupuncture
86 STANLEY ST, AYR, ON, N0B 1E0
PHONE: 519.394.0099
FAX: 519.394.0172

REGISTRATION & HISTORY

Date _____

PATIENT INFORMATION

Name: _____

Address: _____

City Prov. Postal Code

Phone: _____

Work / Cell: _____

Email: _____

Sex: □M □F Age: D.O.B. _____

□ Single □ Commonlaw □ Mar □ Separated □ Divorc □ Widow

Occupation: _____

Employer: _____

Spouse's Name: _____

Occupation: _____

How did you hear about the clinic?

Have you ever been to a chiropractor? □No □Yes (please list)

HEALTH INSURANCE

Extended □ Yes □ No

Please note: we will provide receipts for each visit for you to submit to your insurer - check your coverage and requirements

ACCIDENT INFORMATION

Is condition due to an accident? Y / N Date: _____

Type of Accident □ Auto □Work □ Home □Other

To Whom have you made a report of your accident?

□ Auto Insurance □ Employer □Worker Comp. □ Other

Auto Accident

Name of Auto Ins.: _____

Address: _____

Adjuster's Name: _____

Phone/Fax: _____

Policy No. Date of Loss:

WSIB

Adjudicator Name _____

Claim #: _____

SIN #:

PURPOSE OF CONSULTING WITH OFFICE (PLEASE CHECK ALL THAT APPLY)

□ I am in pain or suffer from a health condition and would like to be examined and treated to get some relief

□ I have no current pain/condition but I am interested in being examined and treated for preventative maintenance

□ I am interested in being assessed for orthotics and/or compression socks/stockings/garments

PATIENT CONDITION

Current symptom(s): _____

When did it start/what caused it? _____

Is this condition getting progressively worse? □Yes □No □Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain □ Sharp □ Dull □ Numbness □ Aching □ Shooting □ Burning
□Tingling □ Throbbing □ Stiffness □ Swelling □ Other _____

Is it constantly there or off and on? _____

Is there anything that relieves it? _____

Activities / Movements that are painful/difficult: □Job/Work □ School □ Sleep □ Daily Routine □ Sports/Recreation
□Sit □ Stand □ Walk □ Bend □ Other _

What treatments have you already received for your condition? □ Medical □ Physio □ None □ Chiro □ Massage □ Other

SYMPTOMS PAST & PRESENT

Please **CIRCLE** any conditions/symptoms that are **PRESENT now**
Please **CHECK** those conditions/symptoms that were there in the **PAST**

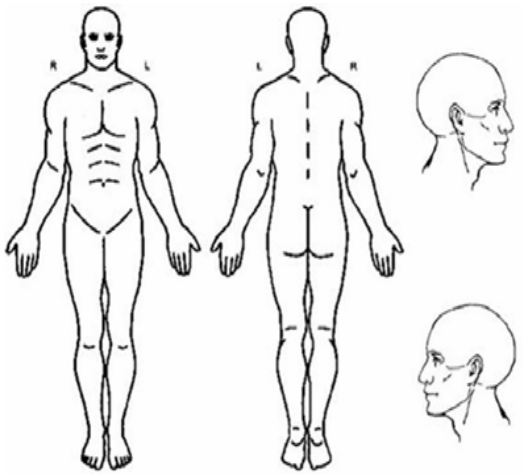
General Symptoms	**Muscles & Joints**	**Eyes, Ear, Nose, Throat**	**Cardiovascular**
Loss of consciousness	Neck pain	Blurred vision	Heart/blood disease
Depression	Upper back pain	Asthma	High blood pressure
Headache	Low back pain	Deafness	Low blood pressure
Fevers	Wrist pain	Ear aches	High cholesterol
Sweats	Hand pain	Ringing/Buzzing in ears	Bleeding disorder
Convulsions	Hip pain	Enlarged glands	Pain over the heart
Loss of Sleep	Knee pain	Hyperthyroidism	Stroke/Heart attack
Numbness, pain, tingling	Foot pain	Hypothyroidism	Swelling of the ankles
Loss of weight	Shoulder pain	**Respiratory**	Poor circulation
Fainting	Arthritis	Difficulty breathing	**Gastrointestinal**
Tremors	Bursitis	Chronic cough	Poor appetite
Allergy	Swollen Joints	Spitting up phlegm/blood	Constipation Diarrhea
Chills	**Skin**	Chest pain	Colitis/irritable bowel
Convulsions	Rashes, itching	**Genitourinary (women)**	Gallbladder trouble
Dizziness	Bruise easily	Excessive menstrual flow	**Other**
Vomiting	Hives or allergy	Painful menstruation	Cancer
Nausea	Varicose veins	Irregular menstrual cycle	Fibromyalgia
		Menstrual cramps	Diabetes

HABITS

□ Smoking	Packs/Day
□ Alcohol	Drinks/Week
□ Caffeine Drinks	Cups/Day
□ High Stress	Reason

EXERCISE	WORK ACTIVITY
□ None	□ Sitting
□ Moderate	□ Standing
□ Heavy	□ Light Labor
	□ Heavy Labor

Draw your injury / pain



INJURIES & SURGERIES YOU HAVE HAD

	Description	Date
Car accidents		
Head Injuries		
Fractures		
Dislocations		
Surgeries		

DO YOU HAVE ANY KIDS? (LIST HOW MANY AND THEIR AGES)

MEDICATIONS (prescription and over the counter)

ALLERGIES

VITAMINS/HERBS/MINERALS/SUPPLEMENTS

Do you suffer from any other health conditions or do you have any other health concerns?

□ No □ Yes (please list)