Bridlewood Chiropractic Clinic
700 Eagleson Road
Kanata, ON K2M 2G9
613-599-9822

PATIENT INFORMATION

Pt # _____

Name:_____ Birth Date: **dd/mm/yy** _____

Age: _____ Gender: M / F What would you like us to call you? _____

Address:_____City:_____Postal Code _____

Phone: (H)_____ (W)_____ ext _____ Cell_____

e-mail address (for clinic use only)_____

Marital Status: S / M / D / W Do you have any children? Y / N Ages: _____

Your occupation: _____

Emergency Contact Name & Phone Number:_____

Family Doctor Name & Address:_____

Date of last appointment or physical: _____

Are you currently under the care of any other doctor(s)? Y / N Doctor Name: _____

For what condition(s)?:_____

Current Symptoms (ie: why are you seeking chiropractic care?) _____

_____

_____

Have you ever been to a chiropractor before? Y / N Name of chiropractor: _____

For what problem? _____ When was your last treatment? _____

Did your family doctor refer you for chiropractic care? Y / N

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

How did you hear about our clinic? friend _____ Who? _____

Sign____ Kanata phone book ___ Yellow Pages Listing ___ Yellow Pages Ad_____ Website _____

Date of last menstrual period _____ Are you currently pregnant? Y / N

Do you currently smoke? Y / N

How often do you exercise and what type of activity is it? _____ times/week

type of activity_____

Do you currently take any prescription or over the counter medications or vitamins / nutritional supplements? Y / N

specify _____

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 **L/R** back pocket **L/R** front pocket **L/R** back pack _____

What is your usual sleep posture? Back Left side Right Side Stomach

What is your daily water intake? ____ 8oz glasses What is your daily caffeinated beverage or soft drink intake? _____ 8oz glasses

I hereby authorize Dr. Chris Paynter, Chiropractor, with my prior knowledge, to release to or obtain any health information from my other healthcare providers as may be required for the management of my case.

Patient signature _____ **Date** _____

I have read and understand the Bridlewood Chiropractic Clinic fee schedule and cancellation policy. Initials_____

Bridlewood Chiropractic Clinic
700 Eagleson Road
Kanata, ON K2M 2G9

Pt # _____

FAMILY HEALTH HISTORY

Have your **grandparents, parents or siblings** ever been diagnosed with any of the following?

High blood pressure	Y / N	Rheumatoid Arthritis	Y / N
Heart Disease	Y / N	Osteoarthritis	Y / N
Stroke	Y / N	Neurological problems	Y / N
Diabetes	Y / N	Cancer	Y / N
Thyroid / Hormone problems	Y / N	Kidney Disease	Y / N
Breathing or lung problems	Y / N	Other specify:	

PATIENT'S HEALTH HISTORY

Have **you** ever experienced or been diagnosed with any of the following? Please tick the box if it applies to you.

[ ] Persistent fatigue
[ ] Recent unexpected change in weight
[ ] Anemia / bruise easily
[ ] Diabetes
[ ] Cancer
[ ] Gout
[ ] Unexplained Swelling
[ ] Rash / Sores that won't heal

[ ] Allergies
[ ] Asthma
[ ] Breathing/Lung problems
[ ] Tuberculosis
[ ] Sinus problems
[ ] Difficulty swallowing
[ ] Productive Cough

[ ] Gastrointestinal problems/pain
[ ] Difficulty and/or changes in urination including incontinence
[ ] Difficulty and/or changes in bowel movements including constipation
[ ] Unexplained Nausea/Vomiting
[ ] Blood in urine, stool, or vomit
[ ] Gallbladder/Liver problems
[ ] Pancreas problems
[ ] Kidney problems
[ ] Thyroid or hormone problems
[ ] Heat/Cold Intolerance

[ ] Breast lump/pain
[ ] Severe menstrual cramps
[ ] Visual problems other than glasses
[ ] Blurred/double vision
[ ] Difficulty or loss of hearing
[ ] Ringing in ears
[ ] Headaches

[ ] Chest pain/discomfort
[ ] High blood pressure
[ ] Stroke
[ ] Heart attack
[ ] Circulation problems
[ ] High cholesterol
[ ] Pacemaker
[ ] Aneurysm

[ ] Blow to/fall on the head
[ ] Dizziness/light head
[ ] Sensory changes
[ ] Weakness
[ ] Seizures / Epilepsy
[ ] Multiple Sclerosis
[ ] Parkinson's
[ ] Cerebral palsy

[ ] Rheumatoid Arthritis
[ ] Osteoarthritis
[ ] Vertebral disc problem
[ ] Fractures
[ ] Dislocations
[ ] Sprains
[ ] Scoliosis
[ ] Osteoporosis
[ ] Prosthesis / joint replacement
[ ] TMJ problems

[ ] neck pain / stiffness
[ ] pinched nerve in neck
[ ] grinding/popping sounds in neck

[ ] mid-back pain / stiffness
[ ] pain from front to back of chest
[ ] tension in shoulders
[ ] pins & needles / numbness
specify where:

[ ] pain in shoulder joint ***L / R***
[ ] can't raise arm above shoulder level ***L / R***
[ ] pain in upper limb ***L / R***
specify where:
[ ] weakness of upper limb ***L / R***
specify where:

[ ] low back pain / stiffness
[ ] pinched nerve in low back
[ ] pain in buttocks ***L / R***

[ ] pain in hip joint ***L / R***
[ ] pain in lower limb ***L / R***
[ ] weakness of leg ***L / R***
[ ] leg cramps ***L / R***

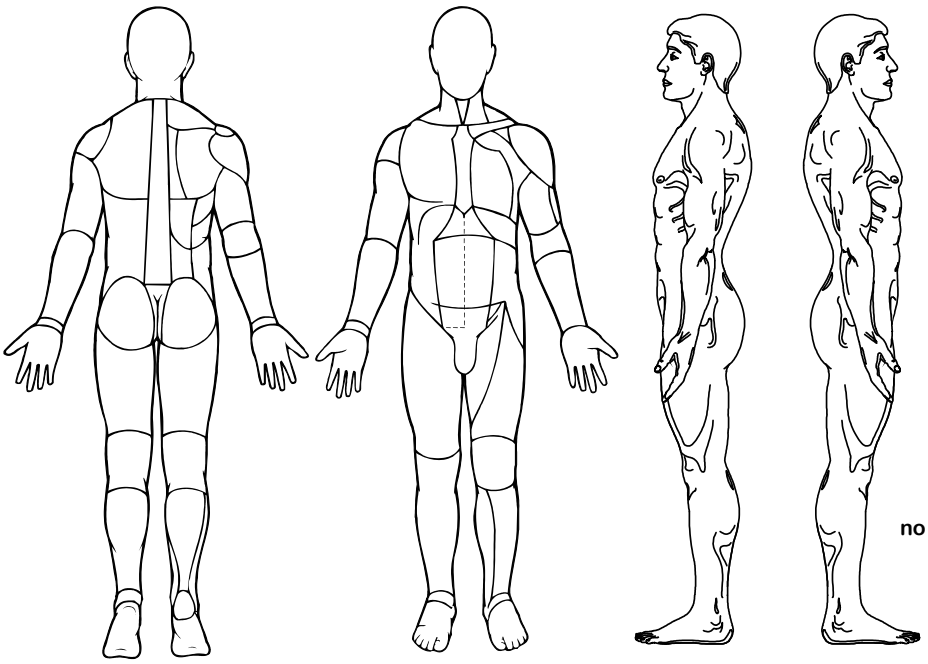
[ ] joint swelling
[ ] surgery
for what?
[ ] car accidents (even minor)

[ ] other:

Signature_____ Date_____

Name:_____ **Date:**_____

Please circle your area of symptoms and indicate the type of symptom and it's severity.



BACK FRONT LEFT RIGHT

ACHE xxxxxxxx

STABBING ////////////

BURNING - - - - - - -

PINS & NEEDLES ::::::::::

NUMBNESS oooooooo

STIFFNESS ********

0 5 10

no symptoms extreme symptoms

Bridlewood Chiropractic Clinic