NOTTINGHILL FAMILY WELLNESS CENTRE

905-827-4197 www.glenabbeychiro.com

Name	**Age**	**D.O.B (Day/Month/Year)**	**Sex** Male ☐ Female ☐
Address	**City**		**Postal Code**
Email Address	**Medical Doctors Name**		
Home Phone ( )	**Cell Phone** ( )	**Work Phone** ( )	
Would you like: Call Reminder ☐ Text Reminder ☐ E-mail Reminder ☐ No Reminder ☐		**Cell Phone Provider:**	
Occupation:		**Employer:**	
Martial Status Single ☐ Married ☐ Divorced ☐ Widowed ☐	**Spouses Name:**	**Spouses Occupation:**	**Do you have children?** YES ☐ NO ☐
Who can we thank for referring you?	**Have you ever had chiropractic care before?** YES ☐ NO ☐	**Emergency Contact (name/phone #)**	

Please indicate any significant slips, falls or motor vehicle accidents that have occurred over your life time.

1. Date ( ) _____

2. Date ( ) _____

Did any of these accidents occur while you were working? YES ☐ NO ☐

WORK HISTORY (Repetitive Strain Protocol)

My Current Occupation Involves:

Lifting (average weight) _____
Sitting: _____ hours per day
Standing:_____ hours per day
Driving: _____ hours per day

Overhead Lifting **YES ☐ NO ☐**
Computer Work **YES ☐ NO ☐**

Repetitive work: ☐ Bending ☐ Twisting ☐ Lifting ☐ Fine Motor Skills

HEALTH HABITS

Did/do smoke ? Quantity _____ **YES ☐ NO ☐**
Did/do drink alcohol? Quantity _____ **YES ☐ NO ☐**
Have you had surgery? **YES ☐ NO ☐**
Prescription Drugs? **YES ☐ NO ☐**
Recreational Drugs? **YES ☐ NO ☐**

Is There a Family History of:

Heart Disease	Yes	No
Diabetes	Yes	No
Stroke	Yes	No
Cancer	Yes	No
High Blood Pressure	Yes	No

What **medications** are you currently taking and for how long have you been consuming them?

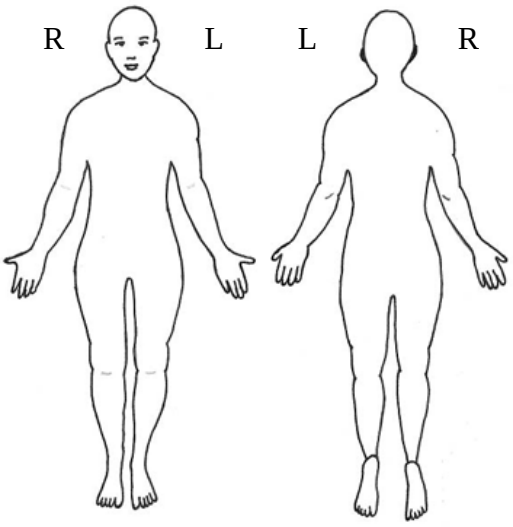
_____

_____

Circle your current level of pain, with 10 being the most severe and 1 being the least painful

1	2	3	4	5	6	7	8	9	10

Present complaint _____
Pain or problem started when _____
Pains are: ☐Sharp ☐Dull ☐Constant ☐Intermittent
Is the condition getting worse? ☐ Yes ☐ No
Any Home Remedies? _____



Please fill the figure in with your current symptom pattern?

+ + +	Pain (dull)	- - -	Pain (sharp)
# # #	Numbness	* * *	Tingling (referral)
P P P	Pressure	C C C	Cramping

Other Symptoms

☐ Headaches
☐ Neck pain/stiffness
☐ Sleeping problems
☐ Back pain
☐ Nervousness
☐ Chest pains
☐ Dizziness
☐ Ringing in ears
☐ Loss of taste/smell
☐ Pins/Needles in Arms
☐ Pins/Needles in Legs
☐ Numbness in fingers
☐ Numbness in toes
☐ Shortness of breath
☐ Fatigue
☐ Depression
☐ Fever
☐ Significant weight loss
☐ Allergies/Asthma
☐ Diarrhea/Constipation
☐ Cold feet/hands
☐ Menstrual problems
☐ Loss of balance
☐ Stroke
☐ Fainting
☐ Night Sweats
☐ Foot Pain

For Women:
Are you pregnant YES ☐ NO ☐ Date of last menstrual cycle? _____
No. of Pregnancies _____ No. of Births _____ No. of Epidurals _____ No. of C- Sections _____

Patient Fee Schedule: New Patient Exam ..... $60.00 Reassessment Exam $60.00
Acute Injury Treatment .... $50.00 Adjustment $38.00

Initial x_____

**** all prices subject to change without notice**

Please make the doctor aware if you are HIV positive or if you any other communicable disease.

I, _____, consent to a physical examination by the chiropractor.
Print Name

Signature _____ **Date** _____