Bloor - Avenue Chiropractic
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Dr. Lynette Nissen ____ Dr. Paul Rankin

PATIENT ADMITTANCE FORM

Welcome to Bloor-Avenue Chiropractic!
Please introduce yourself by filling out the following registration and health history form. A complete history and understanding of your health status are necessary for us to provide you with optimum care.

PERSONAL INFORMATION Date ____________________________

Name ____

How do you wish to be addressed? ____

Date of Birth (d)______(m)______(y)______ Age_______ Female_____ Male_____

Address____Postal Code_______________

City __________________________Email____

Home Phone_____________________________ Cell Phone____________________________

May we call you at work? Yes No Work Phone ___________________________
PLEASE CIRCLE YOUR PRIORITY TELEPHONE NUMBER ABOVE.

Occupation ____________________________________ Employer_________________________

Spouse/Partner _________________________________ Children? Yes No

In case of emergency, whom should we notify? _______________________________________

Relation to you ____________________________Contact number_______________________

Family Doctor_________________________________ Tel ________________________________

Date of last physical ____

How did you hear about our office? ____

If you were referred, whom can we thank? ____

Name: ____ Date: ____________________________

REASON FOR APPOINTMENT

Are you here for a wellness check-up? Yes No

If no, what is your major complaint? ____

____

How long have you had this condition? ____

Have you had this or a similar condition in the past? _____________________________________

What activities aggravate your condition? ____

Is this condition getting progressively worse? Yes No

Is the pain constant? Yes No Or does the pain come and go? Yes No

Is this condition interfering with your ____Work ____Sleep ____ Daily Routine or Other____?

Please specify ____

Are you here as a result of a motor vehicle accident? Yes No

Are you here as a result of a work injury? Yes No

Have you seen your MD or any health care professional for this complaint? Yes No

Did you receive any treatment? Yes No

Have you had previous Chiropractic Care? Yes No

If yes, doctor's name: ____

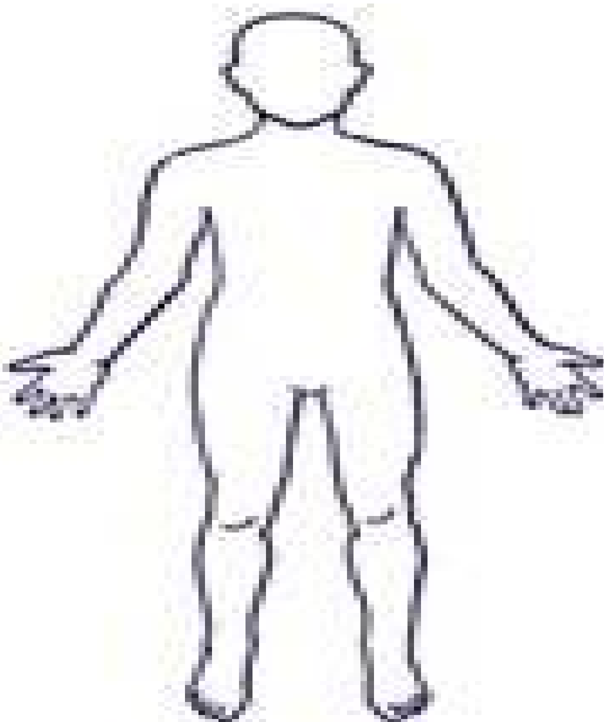
Date of last treatment: ____

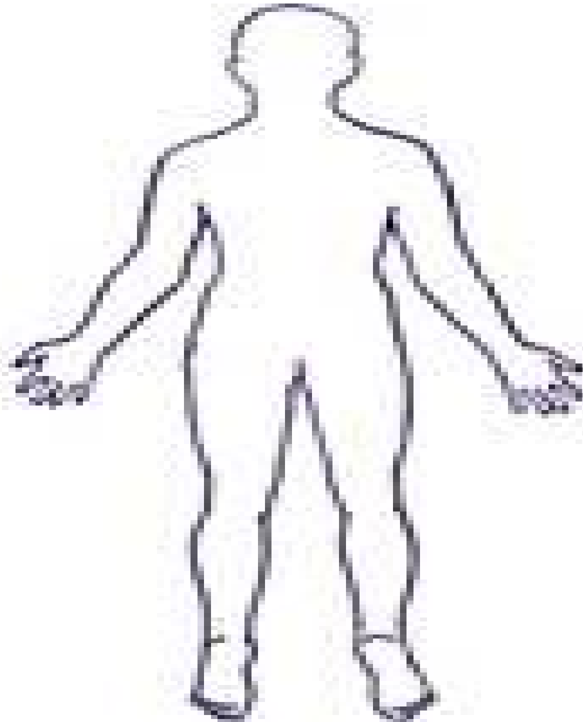
Were X-Rays taken? Yes No If Yes, when? ______________________________________

Using an "X", please rate your current level of pain on the line below.

No pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Very Painful

In the diagrams below, please mark the areas of your pain. To complete the picture, please draw in your face too.





FRONT BACK

Name:____ Date:_____________________________

HEALTH HISTORY

Please write P for symptoms which have been a health concern in the PAST and write C for symptoms that are CURRENT. IF THE SYMPTOM IS NOT APPLICABLE TO YOU, PLEASE LEAVE BLANK.

GENERAL SYMPTOMS
_____ Blackouts
_____ Headaches
_____ Migraines
_____ Fever, Sweats
_____ Fainting
_____ Dizziness
_____ Weight Loss
_____ Loss of Sleep due to pain
_____ Convulsions
_____ Numbness or Tingling in arms/legs
_____ Anxiety
_____ Feelings of extreme stress

MUSCLES AND JOINTS
_____ Neck pain or stiffness
_____ Mid-back pain or stiffness
_____ Low back pain or stiffness
_____ Swollen and painful joints
_____ Foot pain or injury
_____ Knee pain or injury
_____ Shoulder pain or injury
_____ Arm/Forearm pain or injury
_____ Wrist pain or injury
_____ Hand/Finger pain or arthritis
_____ Weakness or loss of strength
_____ Diagnosis of Arthritis
What kind? _________________________

EYES, EARS, NOSE, THROAT
_____ Blurry/Double Vision
_____ Failing Vision (one/both eyes)
_____ Eye pain
_____ Deafness/Hearing loss
_____ Chronic earaches
_____ Ringing/buzzing in one/both ears
_____ Asthma
_____ Frequent colds/flus
_____ Sinus infection
_____ Enlarged lymph glands
_____ Enlarged thyroid
_____Abnormal thyroid function levels
_____ Slurred Speech
_____ Difficulty swallowing

RESPIRATORY
_____ Chronic cough
_____ Spitting up phlegm or blood
_____ Chest pains
_____ Shortness of breath

CARDIOVASCULAR
_____ Varicose Veins
_____ Swelling of the ankles
_____ Angina
_____ Bleeding Disorder
_____ High Blood Pressure
_____ Low Blood Pressure
_____ High cholesterol
_____ Heart Disease

SKIN
_____ Rashes, eczema, itching
_____ Hives
_____ Bruising easily
_____ Dryness
_____ Allergies; to what? _____________

GASTROINTESTINAL
_____ Poor appetite
_____ Indigestion
_____ Hiatus Hernia/Acid Reflux
_____ Recurring Constipation
_____ Chronic Diarrhea
_____ Kidney Stones
_____ Gall Bladder Problems
_____ Irritable Bowel Syndrome
_____ Colitis/Crohns Disease
_____ Celiac Disease

FOR WOMEN ONLY
_____ Painful Menstruation
_____ Excessive Flow
_____ Irregular Cycle
_____ Cramps or Backaches
_____ History of Breast Cancer
Menopausal? __Peri __ Present __ Post
Birth Control Pill? _____Yes _____ No
_____ Diagnosed with Osteoporosis
Number of Pregnancies? _____________
Number of Children? ________________

Name: ____________________ **Date:** ____________________

PREVIOUS TRAUMA

Ever broken a bone(s)? Yes No Explain: ____________________

Any serious strains or sprains? Yes No Explain: ____________________

Hospitalization? Yes No Explain: ____________________

Been unconscious? Yes No Explain: ____________________

Motor vehicle accidents? Yes No Explain: ____________________

Surgery? Yes No Explain: ____________________

Used or use a cane, crutch or other support?______ If Yes, explain____________________

Used or use orthotics, heel lifts, inner soles etc.?______ If Yes, explain____________________

FAMILY HISTORY (Please check the conditions that are applicable)

Arthritis	Heart Disease	Stroke
Auto Immune Condition	High Blood Pressure	Thyroid Issues
Back Pain	High Cholesterol	Vascular Problems
Cancer	Migraines	Other________________
Diabetes	Scoliosis	

DIET

How many meals do you eat per day? 1 2 3 4 4+

Do you have any food sensitivities or restrictions?______ If Yes, explain____________________

Are you a vegetarian? Yes No If Yes, how long? ____________________

How much coffee do you drink per day? Zero 1-2 3-4 5-6 7+

How much pop do you drink per day? Zero 1-2 3-4 5-6 7+

How many glasses of water do you drink/day? 1-3 4-6 7-9 10-12 12+

Do you often feel hypoglycemic (low blood sugar)? Yes No

How many bowel movements do you have a day? Zero 1 2 3 4+

EXERCISE

Do you exercise? Yes No

Most common exercise activities: ____________________

How often per week? ____________________

How are most of your days spent? Standing Sitting Walking Other ____________________

SLEEP

Hours per night? 4-6 6-8 8-10 12+

Do you wake rested? Yes No Do you feel that you're always tired? Yes No

Sleep posture (Circle all that apply): Back Stomach Side

HABITS

How many alcoholic drinks per week? Zero 1-2 3-4 5-6 7+

Are you currently a smoker? Yes No How many cigarettes/day? ____________________

Are you an ex-smoker? Yes No

MISCELLANEOUS

Please list any vitamins, herbs or minerals you take:____________________

Please list any medication you take on a regular basis: ____________________