Integrated Health & Wellness Centre

CONFIDENTIAL PATIENT CASE HISTORY File _____ DATE _____

NAME _____ Age_____

Home Address _____ CITY _____ POSTAL CODE _____

Home Phone _____ Business Phone _____ Ext ___Cellular _____

Date of Birth (D)_____ / (M)_____ / (Y)_____ E-mail _____

Occupation _____ Employed by _____ Full Time or Part Time

Your Medical Doctor _____ Do you wear Orthotics? _____ Heel Lifts?_____ Shoe Lifts? _____

Do you or spouse have Extended Health Care Benefits? _____ If Yes, with who? _____

PAST HISTORY

When answering the following questions, please give applicable dates and details.

Have you had any surgeries or any illnesses? *yes no* _____

Have you ever been hospitalized? *yes no* _____

Have you had any traumas or injuries in the past? *yes no* _____

Have you been in automobile accidents? *yes no* when? _____

Describe your diet (food and vitamin/supplement intake): _____
Previous Chiropractic Care (Dr's name and approximate date of last visit):_____
Do you drink alcohol? *yes no* Number of drinks per week: _____ Smoke Cigarettes? *yes no* Packs per week: _____

Do you use any medications or drugs? *yes no* _____
□ Nerve Pills □ Pain Killers (including aspirin) □ Muscle Relaxants □ Blood Thinners □ Tranquilizers □ Insulin

Reason for today's visit: □ Emergency □ New Injury □ Old Injury □ Chronic Pain □ Maintenance
Is this visit due to a Motor Vehicle Accident (MVA)? Yes □ No □
Is this visit due to a WSIB case and has been reported to your employer? Yes □ No □

What is your **Chief Complaint**? _____
Rate your pain with the following scale: Low Discomfort 1 2 3 4 5 6 7 8 9 10 Intense
What caused it? When did it begin? □ Work □ Sports □ Auto Accident □ Routine / Household Activities

Please explain what happened? _____

Is the condition getting worse? □ Yes □ No □ Constant □ Comes and goes
Is your condition interfering with your, □ Work □ Sleep □ Daily Routine? If so, how: _____

Have you had this similar problem before? □ Yes □ No _____

Have you had any spinal x-rays, cat scans or MRI imaging of your spine or head? *yes no* _____

_____

FAMILY HISTORY

Have your parents, brothers and sisters, or grand parents had any significant illnesses? *yes no*

If yes, please describe: _____

Any family history of: Heart Disease Arthritis Cancer Diabetes

Integrated Health & Wellness Centre Dr. Spyros Karelis DC, FCCPOR(C)
□ 40 Wynford Dr, Suite 300, Toronto, ON, M3C 1J5 416-445-1564
□ 158 Elgin Mills Rd West, Richmond Hill, ON, L4C 4M2 647-404-0854

About Your Health…

PRESENT HEALTH: Are you presently affected by any of the following?

O – OCCASIONAL F – FREQUENT C – CONSTANT

MUSCLE & JOINT	O	F	C
Backache……..	□	□	□
Neck pain……..	□	□	□
Painful Tailbone……	□	□	□
Foot Trouble……	□	□	□
Shoulder Pain……	□	□	□
Hernia……	□	□	□
Spinal Curvature…...	□	□	□
Faulty Posture……..	□	□	□
Arthritis……..	□	□	□
Swollen Joints……..	□	□	□
STRESS SYMPTOMS			
Headache/Migraine..	□	□	□
Dizziness……	□	□	□
Numbness or pins & needles in arms/ legs / feet…..	□	□	□
Ringing in Ears…….	□	□	□
Blurring of Vision…..	□	□	□
Loss of Sleep……	□	□	□
Loss of concentration/ memory ……..	□	□	□
Irritable/Nervousness	□	□	□
Depression…….	□	□	□
Decreased energy/fatigue ……..	□	□	□
Tension……	□	□	□
Forgetfulness…….	□	□	□

GENERAL SYMPTOMS	O	F	C
Fever/Chills/Sweat……	□	□	□
Fainting…….....	□	□	□
Convulsions……	□	□	□
Allergy…….....	□	□	□
Skin Problems……	□	□	□
Colds……..	□	□	□
Tremors……..	□	□	□
Loss of Balance…….....	□	□	□
Easy Bruising……	□	□	□
Loss of Weight……...	□	□	□
RESPIRATORY			
Chronic Cough……	□	□	□
Spitting up Phlegm/Blood	□	□	□
Chest Pain……..	□	□	□
Difficulty breathing…….	□	□	□
Heaviness in chest ……..	□	□	□
URINARY			
Painful Urination……	□	□	□
Getting up at night to Urinate ……	□	□	□
Blood in Urine……	□	□	□
Increased Urination…….....yes□ no□			
Bed Wetting Y or No			

GASTROINTESTINAL	O	F	C
Difficult Digestion……	□	□	□
Belching or Gas…….....	□	□	□
Nausea or Vomiting……	□	□	□
Pain over Stomach……	□	□	□
Constipation……	□	□	□
Colon Trouble……..	□	□	□
Liver Trouble……	□	□	□
Gall Bladder Trouble….....	□	□	□
Heartburn……	□	□	□
Diarrhea……	□	□	□
Bloody Stools……..	□	□	□
Hemorrhoids……	□	□	□
Pancreatitis.....	□	□	□
Ulcers ……..	□	□	□
EYES,EARS,NOSE,THROAT	□	□	□
Tonsillitis……..	□	□	□
Sinus Trouble……..	□	□	□
Deafness……..	□	□	□
Earache……	□	□	□
Ear Discharge……..	□	□	□
Asthma……..	□	□	□
Wear Glasses……..	□	□	□
Soar Throat……..	□	□	□
Nose Bleeds……	□	□	□
Enlarged Glands…….....	□	□	□

CARDIOVASCULAR	O	F	C
Rapid Heart Beat……..	□	□	□
Slow Heart Beat……	□	□	□
High Blood Pressure…	□	□	□
Low Blood Pressure….	□	□	□
Pain over Heart…….	□	□	□
Swelling of Ankles……	□	□	□
Previous Heart Attack	yes□	no□	
Poor Circulation……	yes□	no□	
Previous Stroke……	yes□	no□	
Arteriosclerosis……	yes□	no□	
Paralytic Stroke……..	yes□	no□	
FEMALES ONLY			
Painful Menstruation…	yes□	no□	
Excessive Flow…….	yes□	no□	
Irregular Cycle…….	yes□	no□	
Cramps or Backache...	yes□	no□	
Abnormal Discharge…	yes□	no□	
Passed Menopause….	yes□	no□	
Are you pregnant……..	yes□	no□	
Birth control Pill Pill, IUD, Diaphragm	yes□	no□	
Menopause…….	yes□	no□	
No. of miscarriages _____			
Date of last menstrual period _____			
Number of Children _____			

PAST HEALTH: Have you ever suffered from any of the following conditions?

	Yes	No		Yes	No		Yes	No		Yes	No
Thyroid Trouble……..	□	□	Tuberculosis……...	□	□	Emotional problems……	□	□	Psoriasis……	□	□
Diabetes……..	□	□	Pneumonia……	□	□	Epileptic Seizures……...	□	□	Polio……	□	□
High Blood Pressure	□	□	Back Pain……	□	□	Asthma……	□	□	Cancer……	□	□
Heart Disease……	□	□	Headaches……	□	□	Arthritis……..	□	□	Venereal Disease…….	□	□
Allergies……..	□	□	Stomach Ulcers……	□	□	Alcoholism……	□	□	HIV……..	□	□
Anemia……	□	□	Hospitalizations……..	□	□	Gout……	□	□	Kidney Disease……..	□	□

Please list any significant illness, operations, accidents, falls or traumas, or any other serious medical condition(s) not listed above.

Date	Illness / Operations / Accidents / Falls / Serious Medical Conditions
	Would there be anything else you would like to doctor to know?

We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient. I certify that all the information I have or will complete is/will be correct and that I will not knowingly omit data. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand that any modalities and/treatments techniques will be explained to me with benefits and risks before use, so that I can make an informed decision to follow the therapist's treatment plan. It is my obligation to immediately inform the therapist of any pain, discomfort, fatigue or any symptoms that I may suffer during and immediately after treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I understand that it is my responsibility to pay for any services/ treatment(s) for both myself and my dependents. I assume all responsibility for fees associated with any services or treatment(s) or diagnostic procedures.

Signature _____ Date Signed _____

□ Adult Parent □ Parent or Legal Guardian □ Spouse

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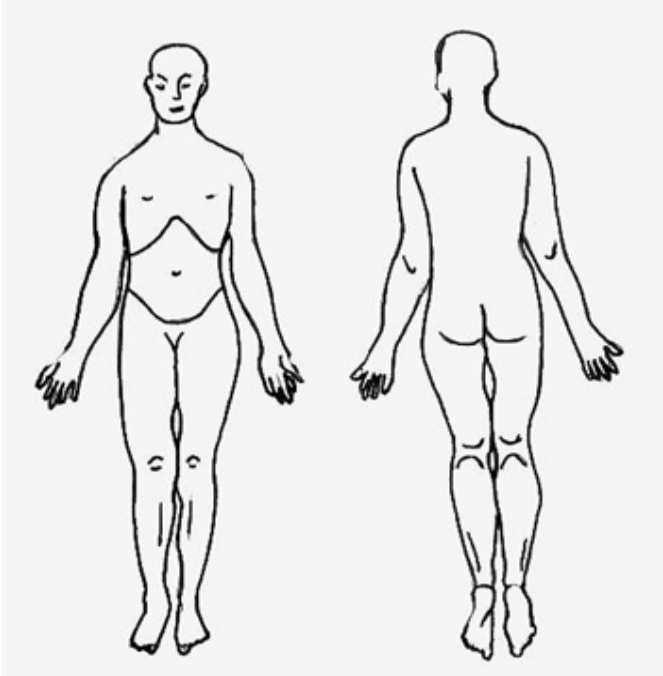
Please fill out the following diagram:

Indicate where your pain is located and what type of pain you feel at the present time. Do not indicate areas of pain that are not related to your present injury or condition. Use the symbols to describe your pain.

KEY:

Pain XXX Stiffness **** Stabbing ///////
Numbness OOO Burning +++ Other (specify) _____



VAS – Visual Analog Scale

Make a mark (/) across the line to indicate how bad your pain is between the extremes of
" **No Pain At All** " on the left of the line and " **Pain As Bad As It Could Be** " on the right of the line.
Make a mark across the line to indicate your **PAIN TODAY** in your major area of injury.

Note: If you have more than one are of pain, mark more than one (/) along the line and indicate the area of the body each mark represents.

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