 Dr. John Kim, D.C.

 180 Ontario St S. Milton Ontario L9T 2M8

 T: 905-878-2333 F: 905-878-1559

 www.kimfamilychiropractic.com

**Welcome to Our Office**

To ensure your visit with us is a pleasant one, here is what you can expect during next 30 minutes.

CONSULTATION . . . . . You will meet the Doctor and he will review your history and determine if yours is a

chiropractic case. You will be informed of the cost of any office procedures before they are performed.

EXAMINATION . . . . . . Standard physical, orthopedic, neurological and chiropractic tests will be performed

to determine the cause(s) of your subluxations.

SPINAL IMAGES . . . . . Necessary views may be taken to visualize the location of any spinal problems, and

neurological interferences, and thus, make your chiropractic care more precise.

NEXT VISIT . . . . . . Before proper care can be rendered, the Doctor will study your examination findings.

Later, you will see your x-rays, review your findings and receive specific care and

recommendations from the Doctor.

**CONFIDENTIAL PATIENT CASE HISTORY**

General Information (Please print clearly) DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Miss Mrs Ms Mr How would you like to be addressed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**Postal Code**:\_\_\_\_\_\_\_\_\_\_\_\_

Home Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Business Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: M F Age: \_\_\_\_\_\_\_\_\_\_\_

Would you like to receive emails for office correspondence and updates? : Yes No

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years employed: \_\_\_\_\_\_\_\_\_\_

MARITAL STATUS:Single Married Divorced Widowed Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and Ages of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW WERE YOU WERE REFERRED TO OUR OFFICE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY COMPLAINT**

Have you had previous Chiropractic care? Yes  No

If yes, how long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Chiropractor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your major complaint for which you are seeking Chiropractic Care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a new condition or an issue for which you have been previously treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other therapies are you seeking for treatment of this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ABOUT YOUR HEALTH**

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in your lowered state of health. At your REPORT OF FINDINGS your Doctor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Present Health: Are you presently affected by any of the following? (within the last 3 months)

 O = Occasionally F = Frequently C = Constantly

**Stress Symptoms O F C** Headache/migraine .   

Dizziness . . . . . . . . . .   

Numbness/pins &

needles in arms/hands, legs/feet . . . . . . . . . . . . .   

Ringing in ears. . . . . .   

Blurring of vision. . . . .  

Loss of sleep . . . . . . . .  

Loss of concentration /memory . . . . . . . . . .   

Irritable/nervousness   

Depression . . . . . . . . .   

Decreased energy

/fatigue . . . . . . . . . . .   

Tension . . . . . . . . . . . .  

 

**Muscle and Joint O F C** Backache . . . . . . . . . .   

Neck Pain. . . . . . . . . .   

Painful tailbone . . . . .   

Foot trouble . . . . . . . .  

Shoulder pain . . . . . .   

Hernia . . . . . . . . . . . . .  

Spinal Curvature . . . .   

Faulty Posture . . . . . .   

Arthritis . . . . . . . . . . .   

 

**Cardiovascular O F C** Rapid heartbeat . . . .   

Slow heartbeat . . . .   

High blood pressure. .   

Low blood pressure . .  

Pain over heart . . . .   

Swelling of ankles . . . .  

Previous heart attack Y N

Poor circulation . . . . .Y N

Previous stroke . . . . . Y N

 

**General Symptoms O F C** Fever/Chills/Sweats .   

Fainting . . . . . . . . . . .   

Convulsions . . . . . . . .   

Allergy . . . . . . . . . . . .  

Skin problems . . . . . .   

Colds . . . . . . . . . . . . . .  

Tremors . . . . . . . . . . .   

Loss of Balance . . . . .   

 

**Respiratory O F C** Chronic cough . . . . . .   

Spitting up phlegm

/ blood . . . . . . . . . . .   

Chest pain . . . . . . . . .   

Difficulty breathing . .  

 

**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 . . . . . . .   

 

**Females Only** Painful menstruation Y N

Excessive flow . . . . . Y N

Irregular . . . . . . . . . . Y N

Cramps or backache Y N

Abnormal discharge Y N

Passed menopause. Y N

Are you pregnant Y N

Birth control pill/shot YN

Number of miscarriages \_\_\_\_\_

Date of last menstrual period

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

**Eyes/Ears/Nose/Throat O F C** Deafness . . . . . . . . . .   

Earache . . . . . . . . . .   

Sore throat . . . . . . . .   

Asthma . . . . . . . . . . . .   

Tonsillitis . . . . . . . . .   

Sinus trouble . . . . . . .  

 

**Urinary O F C** Painful urination . . . .   

Getting up at night to

urinate . . . . . . . . . . .   

Blood in urine . . . . . .   

Increased urination . Y N 

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

Psoriasis Y  N 

Polio Y  N 

Cancer Y  N 

Venereal disease Y  N 

HIV Y  N 

 

Thyroid trouble Y  N 

Diabetes Y  N 

High blood pressure Y  N 

Heart disease Y  N 

Allergies Y  N 

 

Tuberculosis Y  N 

Pneumonia Y  N 

Back pain Y  N 

Headaches Y  N 

Stomach Ulcers Y  N 

 

Emotional concern Y  N 

Epileptic Seizures Y  N 

Asthma Y  N 

Arthritis Y  N 

Alcoholism Y  N 

 

|  |  |
| --- | --- |
| Date | Please list any significant illness, surgeries, accidents, falls or traumas |
|  |  |
|  |  |
|  |  |
|  |  |