Drs Mekis & McIntosh
Chiropractic Professional Corporation#01631-12
140-1 Elder Street, Gravenhurst ON P1P 1B9

Patient Information

Thank you for choosing our practice for your chiropractic care. If you have any questions, do not hesitate to ask for assistance. We will be happy to help!

(Please Print)

Name_____ Date _____ ❑Male ❑Female
First Last

Address _____ City_____ Prov _____Postal Code_____

Date of Birth _____ Home Phone# _____Work Phone #_____
YYYY MM DD

Do you prefer to receive calls at: ❑Either ❑Home ❑Work ❑Cell

Email Address: _____ Cell#_____

Would you like to receive our free health newsletters by email ❑Yes ❑No

Employer_____ Occupation _____

Is your condition the result of a motor vehicle injury or work-related injury? If yes, Date of accident _____

Who is your medical doctor? _____ Date of last check-up or physical? _____

Have you previously received chiropractic care? ❑Yes ❑No _____
Name of Chiropractor Date of last visit

Do you have extended health coverage? Name: _____

How did you hear about our office? ❑Yellow Pages ❑Newspaper ❑Internet ❑Sign ❑Other_____

❑Patient (Name)_____ ❑Physician (name) _____

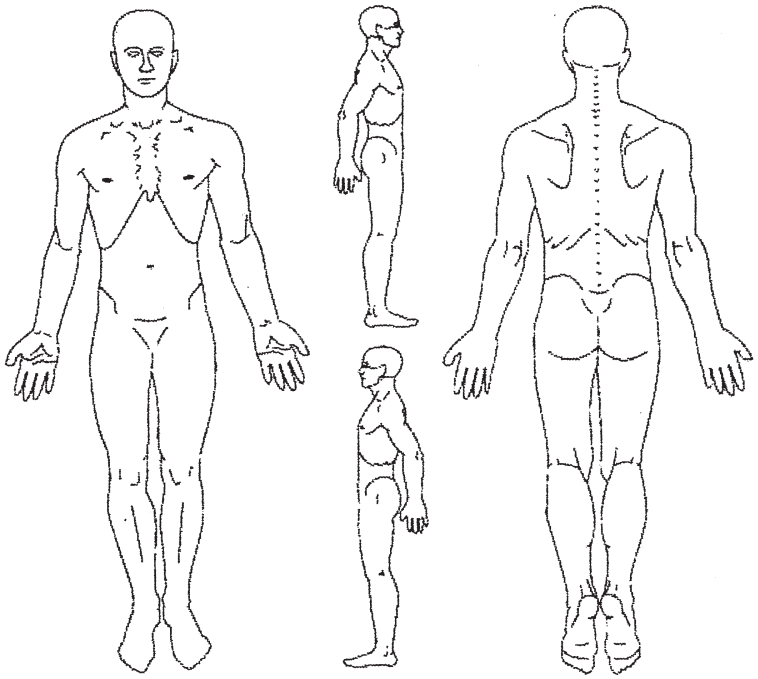
Health Information

Are you currently experiencing pain or discomfort ❑Yes ❑No

If no, please proceed to page 2

Date when you first notice symptoms_____

Use the diagram mark the location of your pain:



What description fits your symptoms?

❑Sharp ❑Throbbing ❑Dull ❑Numbness
❑Aching ❑Shooting ❑Burning ❑Tingling
❑Stiffness ❑Swelling ❑Cramping ❑Other

Circle the severity of your pain or discomfort:
(1= mild pain or discomfort; 10 = severe pain)

1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

❑Constantly (76 - 100% of the day)
❑Frequently (51 - 75% of the day)
❑Occasionally (26 - 50% of the day)
❑Intermittently (0 - 25% of the day)

How are your symptoms changing?

❑Getting Better ❑Not Changing ❑Getting Worse

What treatment have you already received for this?

❑Medication ❑Chiropractic ❑Physiotherapy
❑Massage Therapy ❑No treatment to date
❑Surgery Date of Surgery _____
❑Other _____

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Lifestyle

How often do you participate in cardiovascular exercise? (walking, running, swimming for 30 minutes) ❑Never ❑1-2 days/wk ❑3-4 days/wk ❑Most days

How often do you perform strengthening exercises? (weight-lifting) ❑Never ❑1-2 days/wk ❑3-4 days/wk ❑Most days

How often do you perform flexibility exercises? (Yoga, Tai Chi, Dance, etc.) ❑Never ❑1-2 days/wk ❑3-4 days/wk ❑Most days

What do your daily work habits include? ❑Sitting ❑Walking ❑Standing ❑Light Labour ❑Heavy Labour ❑Computer Work ❑Driving ❑Lifting ❑Other _____

How do you rate your current stress? (circle) 1 2 3 4 5 6 7 8 9 10
Low High

Do you eat a healthy diet? ❑Yes ❑No How much water do you drink per day?_____

Do you smoke? ❑Yes ❑No How many cigarettes per day?_____Number of years?_____

Do you consume alcohol? ❑Yes ❑No If yes, how many drinks per week?_____

How many hours of sleep do you get nightly?_____Do you awake feeling rested? ❑Yes ❑No

How do you sleep? ❑Side ❑Back ❑Stomach ❑All

What vitamins or supplements do you take? _____

_____

List all medications you are taking: _____

_____

List all surgeries and when they occurred: _____

_____

Health History

Check only those conditions which are applicable

Past	Present		Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	High Blood Pressue	❑	❑	Diabetes
❑	❑	Neck Pain	❑	❑	Heart Attack	❑	❑	Excessive Thirst
❑	❑	Back Pain	❑	❑	Chest Pains	❑	❑	Frequent Urination
❑	❑	Shoulder Tendonitis	❑	❑	Stroke	❑	❑	Anxiety
❑	❑	Frozen Shoulder	❑	❑	Angina	❑	❑	Depression
❑	❑	Tennis/Golfer's Elbow	❑	❑	Kidney Disorders	❑	❑	General Fatigue
❑	❑	Wrist/Hand Pain	❑	❑	Bladder Infection	❑	❑	Fibromyalgia
❑	❑	Carpal Tunnel Syndrome	❑	❑	Painful Urination	❑	❑	Asthma
❑	❑	Hip/Upper Leg Pain	❑	❑	Loss of Bladder Control	❑	❑	Allergies
❑	❑	Knee/Lower Leg Pain	❑	❑	Prostate Problems	❑	❑	Epilepsy
❑	❑	Ankle/Foot Pain	❑	❑	Loss of Appetite	❑	❑	Dermatitis/Rash
❑	❑	Plantar Fasciitis/Heel Spurs	❑	❑	Abnormal Weight Gain/Loss			
❑	❑	Joint Swelling/Stiffness	❑	❑	Abdominal Pain	**Females**		
❑	❑	Jaw Pain	❑	❑	Ulcer	❑	❑	Birth Control Pills
❑	❑	Osteoarthritis	❑	❑	Liver/Gall Bladder Disorder	❑	❑	HRT
❑	❑	Rheumatoid Arthritis	❑	❑	Hepatitis	❑	❑	Pregnancy
❑	❑	Osteoporosis	❑	❑	Tumour			
❑	❑	Scoliosis	❑	❑	Cancer	**Any other conditions indicate below:**		
❑	❑	Loss of Coordination	❑	❑	HIV/AIDS	❑	❑	_____
❑	❑	Visual Disturbances	❑	❑	Systemic Lupus	❑	❑	_____
❑	❑	Dizziness	❑	❑	Hypo/hper-thyroid	❑	❑	_____