Ajax Chiropractic & Wellness

#20-314 Harwood Ave. South, Ajax, ON L1S 2J1
Phone # (905) 426-9004 Fax# (905) 426-8253

Patient Entrance Form

Last Name: _____ First Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Tel: _____ Work Tel: _____ Cell #: _____

Birthday (D/M/Y): ____/____/____ Age: ____ Gender: M / F E-Mail:_____

Marital Status: _____ No. of children: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Extended Health Care Coverage per Year: _____

How did you hear about our office? Yellow Pages / Sign / Friend / Other: _____

Primary Care Physician: _____ Phone #: _____

Date of Last Appointment: _____ Date of Last Physical: _____

Previous Chiropractic Care: YES NO

Name of Chiropractor: _____ City: _____

X-rays taken? YES NO How long ago? _____

Results? EXCELLENT GOOD FAIR POOR

Please describe your current problem _____

What makes it better? _____

What makes it worse? _____

Is your current problem the result of:

Auto Accident? □Yes □No Work Accident? □Yes □No Slip & Fall? □Yes □No

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Patient Health Questionnaire

Please check any of the following conditions you have now or have had in the past. Knowledge of these conditions may influence the type of treatment/therapy you receive.

Now Past

MUSCULOSKELETAL:

- □ □ Arthritis
- □ □ Herniated Disc
- □ □ Jaw Problems
- □ □ Metal Implants
- □ □ Muscle/Joint Injury
- □ □ Osteoporosis
- □ □ Pain – Neck
- □ □ Pain – Mid Back
- □ □ Pain – Low Back
- □ □ Pain – Arm/Elbow
- □ □ Pain – Hand
- □ □ Pain – Wrist
- □ □ Pain – Shoulder
- □ □ Pain – Ankle/Foot
- □ □ Pain – Leg
- □ □ Pain – Knee
- □ □ Scoliosis

NERVOUS SYSTEM:

- □ □ Concussion/Head Injury
- □ □ Dizziness
- □ □ Epilepsy/Seizures
- □ □ Fainting
- □ □ Memory Problems
- □ □ Motion Sickness
- □ □ Nervous System Disorder
- □ □ Neuritis

EENT:

- □ □ Chronic Earaches
- □ □ Chronic Sinusitis
- □ □ Difficulty Swallowing
- □ □ Ear/Hearing Problems
- □ □ Eye/Visual Problems
- □ □ Sinus Trouble
- □ □ Tinnitus(Ear Noises)

Now Past

CARDIOVASCULAR:

- □ □ Anemia
- □ □ Angina
- □ □ Aortic Aneurysm
- □ □ Blood Disorder/Clots
- □ □ Chest Pain
- □ □ Circulatory Problems
- □ □ Heart Attack/Disease
- □ □ Heart Murmur
- □ □ Heart Surgery
- □ □ High Blood Pressure
- □ □ Low Blood Pressure
- □ □ Pacemaker/Any Implants
- □ □ Rapid Heartbeat
- □ □ Stroke
- □ □ Varicose Veins

RESPIRATORY:

- □ □ Asthma
- □ □ Chronic Cough
- □ □ Emphysema/Bronchitis
- □ □ Lung Disease
- □ □ Pneumonia
- □ □ Tuberculosis

GASTRO-INTESTINAL:

- □ □ Colitis
- □ □ Constipation
- □ □ Diabetes
- □ □ Digestive Disorders
- □ □ Excessive Thirst
- □ □ Gallbladder Problems
- □ □ Heartburn/Indigestion
- □ □ High Cholesterol
- □ □ Liver Problems
- □ □ Liver Disease/Hepatitis
- □ □ Ulcer
- □ □ Vomiting

Now Past

GENITO-URINARY:

- □ □ Bladder Infection
- □ □ Incontinence
- □ □ Kidney Disorders
- □ □ Loss of Bladder Control

FEMALE/MALE:

- □ □ Breast Lump
- □ □ PMS
- □ □ Prostate Problems
- □ □ Pregnancies (#_____)

GENERAL:

- □ □ Allergies
- □ □ Anxiety/Panic Attacks
- □ □ Chronic Fatigue
- □ □ Depression
- □ □ Headache
- □ □ Hernia
- □ □ Immune System Disease
- □ □ Multiple Sclerosis
- □ □ Rheumatic Fever
- □ □ Skin Disorders
- □ □ Sleep Disturbance
- □ □ Thyroid Disease
- □ □ Other _____
  _____

Height: _____ feet _____ inches

Weight: _____ pounds

For all patients over 13 yrs. old:

□ Smoking - Packs/Day_____
□ Alcohol - Drinks/Week _____
□ Coffee/Caffeine Drinks - Cups/Day _____
□ Alcohol Dependence
□ Drug Dependence

Please list all allergies including allergies to medications _____

_____

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List all medications you are presently taking (including vitamins & supplements) _____

_____

List any surgeries, fractures, serious illnesses or hospitalizations _____

_____

Describe your eating habits? □ Home cooked, healthy meals □ Home cooked, processed foods
□ Take out/restaurants

Describe your sleep style: □ Sound sleeper □ Light sleeper □ Wake up frequently

Describe your sleep position: □ Side □ Back □ Stomach

Describe your stress level: □ None to mild □ Moderate □ High

Do you exercise? □ Yes, almost daily □ Yes, occasionally □ Not at all

Describe your job requirements: □ Mainly Sitting □ Light Labor □ Heavy Labor

Family Health History:

If a family member has had any of the following, please mark the appropriate box:

(Family members can include brothers, sisters, parents, grandparents, aunts, uncles)

□ Cancer □ Diabetes (I/II) □ Heart Attacks □ High Blood Pressure □ Chronic Headaches

□ Stroke □ Lung Disease □ Circulation Problems □ Chronic Back Problems □ Rheumatoid Arthritis

□ Epilepsy □ Osteoporosis □ Alcoholism □ Other _____

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge.

I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature _____ Date _____

PATIENT COMMUNICATION AUTHORIZATION

Chiropractors at Ajax Chiropractic & Wellness and members of its staff may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with the person who answers the phone. By signing this form, you are giving us authorization to contact you with these reminders and information.
PLEASE REVIEW AND ASK ANY QUESTIONS BEFORE SIGNING.

Patient or Guardian Signature _____ Date _____

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DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please know that we are very concerned with protecting the privacy of your personal health information. While the law requires us to notify you about this disclosure, please understand that we have, and always will, respect the privacy of your health information. However, please be advised that it may be necessary for us to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. I have read the above privacy pledge and agree to its terms.

Patient or Guardian Signature _____ Date _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Dr. Tanya Slapnicar B.Sc. (Hons.), D.C.
Dr. Amanda Graham, B.Sc.K., D.C.

Chiropractors locate, analyze and correct *subluxations* (spinal misalignments which cause nerve interference). Chiropractic improves the nerve supply to your entire body and allows the *innate healing power or your body* to work at maximum efficiency to restore, maintain and promote health.

Chiropractic care is considered to be one of the safest and most effective forms of health care. As in all health care, however, there are some slight and minimal risks to chiropractic care, including, but not limited to, minor muscle strains and sprains, disc injuries and strokes. Tests will be performed on you to minimize this risk and the appropriate chiropractic adjusting techniques will be applied.

The doctor and/or staff will always be available to answer questions and discuss the nature and purpose of chiropractic procedures. Results cannot be guaranteed, as every person is unique.

"I have read the above and wish to rely on the doctor to exercise judgment during the course of my care which the doctor feels at the time, based on the facts then known, is in my best interest. I intend this consent to cover the entire course of treatment, including any x-rays that may be required, for my present condition and for any future condition(s) for which I seek treatment".

_____ _____ _____
Patient's Name Patient's Signature Date

Female Patients – Please read and complete

All women of childbearing age must sign this release. *"This is to certify that to the best of my knowledge, I am not pregnant and that Ajax Chiropractic & Wellness has my permission to take x-rays. I will assume all responsibility should I be pregnant."*

First day of last menstrual cycle Date: _____Signature: _____