Ajax Chiropractic & Wellness

314 Harwood Ave. South, Unit 20 Ajax, ON L1S 2J1 Phone # (905) 426-9004
Dr. Tanya Slapnicar Dr. Derek Ginter

Patient Entrance Form

Last Name: _____ First Name:_____ Date: _____

Address: _____ City: _____ Province:____ Postal Code:_____

Home Tel: _____ Work Tel: _____Cell #: _____

Email:_____ I do not wish to be contacted by email □

Birthday (Y/M/D): ____/____/____ Age: _____ Gender: M / F Identifies as (if applicable): _____

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

Emergency Contact: _____ Phone #: _____ Relationship:_____

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

Primary Care Physician: _____ Phone #: _____

Previous Chiropractic Care: □ YES □ NO

Please describe your current problem

_____

Describe what it feels like: □ sharp □ stabbing □ dull □ ache □ tightness □ pulling □ burning

□ numbness □ tingling □ pins & needles □ throbbing □other:_____

On the following scale please circle the intensity/severity of your pain:

(no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

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

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

Patient or Guardian Signature _____ Date _____

DO NOT SIGN UNTIL AFTER THE CHIROPRACTOR HAS TAKEN YOUR HISTORY

I give my consent for the chiropractor to conduct a physical examination.

Patient or Guardian Signature _____ Date _____

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