File #: _____

Date: _____

Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

General Information

Last Name: _____ **D.O.B.** _____

First Name: _____

How do you wish to be addressed in our office? *(First Name, Mr., Mrs., Dr., Nickname, Etc…)*

_____

Identify as? ☐ M ☐ F ☐ Other: **Sex at birth:** ☐ M ☐ F

Address: _____

Town/City: _____ **Province:** _____ **Postal Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ _____ **Please Initial** Consent to receive email communication from the clinic

How do you wish to be contacted by our office regarding your appointments?
Email Phone

Occupation: _____ **Spouse's name** *(if applicable)*: _____

Children: ☐ Y ☐ N **Number:** _____ **Ages:** _____

(Females) Are you pregnant? ☐ Y ☐ N **How many weeks?** _____ **Estimated due date:** _____

Family Dr. Name: _____ **Phone:** _____

Current / Previous Wellness Care? *(check all that apply)*

Chiropractic Physiotherapy Naturopathy Massage Therapy Osteopathy

Location: _____

How did you hear about us? ***(referral, ad, Google)*** _____

Reason for consulting the office:

- ☐ I have a specific problem and require help only with this problem.
- ☐ After my specific problem has been relieved, I am interested in strategies for maintenance.
- ☐ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
- ☐ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

Chiropractic - Pregnancy Intake

File #: _____

Date: _____

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Health History

The following health history is designed to uncover all areas of ill health. As the human body is designed to be healthy, any deviation from optimal health will reduce your body's wellness potential. A detailed history can give your chiropractor valuable insight into the wellness condition of your body prior to your pregnancy. Your health history includes your journey from childhood to present. Please take the time to fully complete this form to the best of your ability:

A. Growth and Development

☐ Y ☐ N **To your knowledge, were there any difficulties or interventions employed at your own birth? (difficult delivery, forceps, vacuum extraction, epidural, c-section)**

Explain: _____

☐ Y ☐ N **To your knowledge, did you ever experience a fall (out of bed, off a change table, table etc.) as an infant/toddler?**

Explain: _____

☐ Y ☐ N **Childhood Illnesses?** **Details:** _____

☐ Y ☐ N **Childhood Accidents? (include sports injuries, slips and falls, etc.)**

Explain: _____

☐ Y ☐ N **Did you ever play contact sports?**

☐ Y ☐ N **Have you ever been told you have a scoliosis?**

☐ Y ☐ N **Any other childhood traumas?**

Explain: _____

☐ Y ☐ N **Were you vaccinated as a child?**

File #: _____

B. Current Health Status

☐ Y ☐ N **Have you had any past surgeries? If so, what?:** _____

Explain: _____

☐ Y ☐ N **Do/did you smoke?** **Date quit:** _____

☐ Y ☐ N **Do/did you vape?** **Date quit:** _____

☐ Y ☐ N **Do you drink any alcohol? If so, how much/week?** _____

☐ Y ☐ N **Do you feel that you have an adequate diet, especially vegetables?**

☐ Y ☐ N **Have you ever been in a motor vehicle collision (include minor ones)?**

Explain: _____

☐ Y ☐ N **Have you had any other accidents, trauma or fractures?**

Explain: _____

☐ Y ☐ N **Previously diagnosed medical conditions? List:** _____

_____

☐ Y ☐ N **Does your job and/or daily activities require that you do a lot of twisting?**

☐ Y ☐ N **Drugs / Prescription / Over the Counter / Recreational / Birth Control**

If yes, list drug and condition: _____

_____

☐ Y ☐ N **Dental problems?**

Explain: _____

☐ Y ☐ N **Hearing problems?**

Explain: _____

☐ Y ☐ N **Regular Exercise?** **Aerobic** **Non-Aerobic** _____ **x/week**

Stress: **Occupational** **Physical** **Mental**

Sleeping Posture: **Back** **Front** **Side** **Hours of Sleep:** _____ **/Night**

File #: _____

C. Health Symptoms

Please briefly describe any current painful symptoms you are experiencing: _____

_____

_____

How long ago did the problem start? _____

Did you have the problem prior to your pregnancy? ☐ Y ☐ N

The pain you experience is: ☐ CONSTANT ☐ OCCASIONAL

What aggravates your pain or problem? _____

What relieves your pain or problem? _____

Does your pain radiate or travel to other parts of your body? ☐ Y ☐ N

Does your condition get worse at certain times of the day or night? _____

How long does the pain last when you get the pain? _____

Is your condition: ☐ **WORSENING** ☐ **IMPROVING**

Have you consulted other health professionals regarding this problem? ☐ Y ☐ N

If yes, which ones? _____

Have you taken any medications for this problem? ☐ Y ☐ N

If yes, what medication and for how long? _____

Family History of: Heart Disease Stroke Cancer Diabetes

Other: _____

File #: _____

D. Other Symptoms

Please check a box if you currently experience or have experienced any of these in the past:

Headaches	Numbness in toes	Loss of taste
Neck pain	Shortness of breath	Diarrhea
Back pain	Fatigue	Stomach upset
Sleeping problems	Depression	Abdominal pain
Stress	Memory loss	Constipation
Irritability	Ringing in ears	Cold sweats
Chest pains	Ear infections	Fever
Dizziness	Heart trouble	Prostate problems
Stiff neck	Circulation problems	Hepatitis B
Pins & needles in legs	Loss of balance	HIV
Pins & needles in arms	Fainting	Trouble with bowel or bladder control
Numbness in fingers	Loss of smell	
Painful menstruation	Stroke	Reproductive problems (endometriosis, fibroids, impotence, etc.)

<u>Expectations</u>:

Please list your top 3 expectations that you have regarding your care at Waterdown Village Chiropractic & Wellness Group:

1. _____
2. _____
3. _____