File #: ______________________

Date: ______________________

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.

Physiotherapy - Adult

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Health History

A detailed history can give your physiotherapist valuable insight into the condition of your body. Please take the time to **fully complete** this form to the best of your ability:

A. Health Symptoms

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

____

____

How long ago did the problem start? ______________________

The pain you experience is: CONSTANT INTERMITTENT

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? ______________________

File #: ______________________

B. Current Health Status (Please check either Y or N)

Y N **Have you had any past surgeries? If so, what?** ______________________

Y N **Do/did you smoke/vape?** **Date quit:**______________________

Y N **Do/did you drink 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 **Drugs / Prescription / Over the Counter / Recreational / Birth Control**

If yes, list drug and condition: ______________________

____

Y N **Regular Exercise?** Aerobic Non-aerobic _______ x/Week

Stress: Occupational Physical Mental

Y N **Do you suffer from disturbed sleep?**

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

Expectations:

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

1. ______________________
2. ______________________
3. ______________________

File #: ______________________

Please check a box if you currently experience, or have had a problem with in the past, any of these:

Headaches	Numbness in toes	Loss of taste
Neck pain	Shortness of breath	Diarrhea
Back pain	Fatigue	Stomach upset
Sleeping problems	Stroke	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	Anxiety	Reproductive problems (endometriosis, fibroids, impotence, etc.)
Painful menstruation	Depression	
Dental problems	Hearing problems	

Family History of: Heart Disease Stroke Cancer Diabetes

Other: ____

____

____