



Bridlewood Chiropractic Clinic  
 320 Eagleson Road Unit D3A  
 Kanata, ON K2M 1C9  
 613-599-9822

PATIENT INFORMATION

Pt # \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: dd/mm/yy \_\_\_\_\_

Age: \_\_\_\_\_ Gender: M / F What would you like us to call you? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ ext \_\_\_\_\_ Cell \_\_\_\_\_

e-mail address (for clinic use only) \_\_\_\_\_

Marital Status: S / M / D / W Do you have any children? Y / N Ages: \_\_\_\_\_

Your occupation: \_\_\_\_\_

Emergency Contact Name & Phone Number: \_\_\_\_\_

Family Doctor Name & Address: \_\_\_\_\_

Date of last appointment or physical: \_\_\_\_\_

Are you currently under the care of any other doctor(s)? Y / N Doctor Name: \_\_\_\_\_

For what condition(s): \_\_\_\_\_

Current Symptoms (ie: why are you seeking chiropractic care?) \_\_\_\_\_

Have you ever been to a chiropractor before? Y / N Name of chiropractor: \_\_\_\_\_

For what problem? \_\_\_\_\_ When was your last treatment? \_\_\_\_\_

Did your family doctor refer you for chiropractic care? Y / N

WAS THIS AN INJURY THAT OCCURRED AT WORK? Y / N Was it reported? Y / N WSIB# \_\_\_\_\_

WAS THIS AN INJURY AS A RESULT OF A CAR ACCIDENT? Y / N Is there a claim pending? Y / N

How did you hear about our clinic? friend \_\_\_\_\_ Who? \_\_\_\_\_

Sign \_\_\_\_\_ Kanata phone book \_\_\_\_\_ Yellow Pages Listing \_\_\_\_\_ Yellow Pages Ad \_\_\_\_\_ Website \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_ Are you currently pregnant? Y / N

Do you currently smoke? Y / N

How often do you exercise and what type of activity is it? \_\_\_\_\_ times/week

type of activity \_\_\_\_\_

Do you currently take any prescription or over the counter medications or vitamins / nutritional supplements? Y / N

specify \_\_\_\_\_

Do you use any devices such as cervical pillows, orthotics, back supports, braces, etc? Y / N

specify \_\_\_\_\_

Where do you carry your wallet or purse?

Over shoulder L/R back pocket L/R front pocket L/R back pack \_\_\_\_\_

What is your usual sleep posture? Back Left side Right Side Stomach

What is your daily water intake? \_\_\_\_\_ 8oz glasses What is your daily caffeinated beverage or soft drink intake? \_\_\_\_\_ 8oz glasses

I hereby authorize Dr. Chris Paynter, Chiropractor, with my prior knowledge, to release to or obtain any health information from my other healthcare providers as may be required for the management of my case.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

I have read and understand the Bridlewood Chiropractic Clinic fee schedule and cancellation policy. Initials \_\_\_\_\_

### FAMILY HEALTH HISTORY

Have your grandparents, parents or siblings ever been diagnosed with any of the following?

High blood pressure	Y / N	Rheumatoid Arthritis	Y / N
Heart Disease	Y / N	Osteoarthritis	Y / N
Stroke	Y / N	Neurological problems	Y / N
Diabetes	Y / N	Cancer	Y / N
Thyroid / Hormone problems	Y / N	Kidney Disease	Y / N
Breathing or lung problems	Y / N	Other <u>specify</u> :	

### PATIENT'S HEALTH HISTORY

Have you ever experienced or been diagnosed with any of the following? Please tick the box if it applies to you.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Persistent fatigue   | <input type="checkbox"/> Chest pain/discomfort                              | <input type="checkbox"/> pain in shoulder joint L / R                          |
| <input type="checkbox"/> Recent unexpected change in weight                                     | <input type="checkbox"/> High blood pressure                                | <input type="checkbox"/> can't raise arm above shoulder level<br>L / R         |
| <input type="checkbox"/> Anemia / bruise easily   | <input type="checkbox"/> Stroke   | <input type="checkbox"/> pain in upper limb L / R<br><u>specify where:</u>     |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Heart attack                                       | <input type="checkbox"/> weakness of upper limb L / R<br><u>specify where:</u> |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Circulation problems                               |  |
| <input type="checkbox"/> Gout   | <input type="checkbox"/> High cholesterol                                   | <input type="checkbox"/> low back pain / stiffness                             |
| <input type="checkbox"/> Unexplained Swelling   | <input type="checkbox"/> Pacemaker  | <input type="checkbox"/> pinched nerve in low back                             |
| <input type="checkbox"/> Rash / Sores that won't heal   | <input type="checkbox"/> Aneurysm   | <input type="checkbox"/> pain in buttocks L / R                                |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Blow to/fall on the head                           | <input type="checkbox"/> pain in hip joint L / R                               |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Dizziness/light head                               | <input type="checkbox"/> pain in lower limb L / R                              |
| <input type="checkbox"/> Breathing/Lung problems  | <input type="checkbox"/> Sensory changes                                    | <input type="checkbox"/> weakness of leg L / R                                 |
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Weakness   | <input type="checkbox"/> leg cramps L / R                                      |
| <input type="checkbox"/> Sinus problems   | <input type="checkbox"/> Seizures / Epilepsy                                |  |
| <input type="checkbox"/> Difficulty swallowing  | <input type="checkbox"/> Multiple Sclerosis                                 | <input type="checkbox"/> joint swelling  |
| <input type="checkbox"/> Productive Cough   | <input type="checkbox"/> Parkinson's  | <input type="checkbox"/> surgery<br><u>for what?</u>                           |
| <input type="checkbox"/> Gastrointestinal problems/pain   | <input type="checkbox"/> Cerebral palsy                                     | <input type="checkbox"/> car accidents (even minor)                            |
| <input type="checkbox"/> Difficulty and/or changes in urination<br>including incontinence       | <input type="checkbox"/> Rheumatoid Arthritis                               |  |
| <input type="checkbox"/> Difficulty and/or changes in bowel<br>movements including constipation | <input type="checkbox"/> Osteoarthritis                                     | <input type="checkbox"/> <u>other:</u>   |
| <input type="checkbox"/> Unexplained Nausea/Vomiting  | <input type="checkbox"/> Vertebral disc problem                             |  |
| <input type="checkbox"/> Blood in urine, stool, or vomit  | <input type="checkbox"/> Fractures  |  |
| <input type="checkbox"/> Gallbladder/Liver problems   | <input type="checkbox"/> Dislocations                                       |  |
| <input type="checkbox"/> Pancreas problems  | <input type="checkbox"/> Sprains  |  |
| <input type="checkbox"/> Kidney problems  | <input type="checkbox"/> Scoliosis  |  |
| <input type="checkbox"/> Thyroid or hormone problems  | <input type="checkbox"/> Osteoporosis                                       |  |
| <input type="checkbox"/> Heat/Cold Intolerance  | <input type="checkbox"/> Prosthesis / joint replacement                     |  |
|   | <input type="checkbox"/> TMJ problems                                       |  |
| <input type="checkbox"/> Breast lump/pain   | <input type="checkbox"/> neck pain / stiffness                              |  |
| <input type="checkbox"/> Severe menstrual cramps  | <input type="checkbox"/> pinched nerve in neck                              |  |
| <input type="checkbox"/> Visual problems other than glasses                                     | <input type="checkbox"/> grinding/popping sounds in neck                    |  |
| <input type="checkbox"/> Blurred/double vision  |   |  |
| <input type="checkbox"/> Difficulty or loss of hearing  | <input type="checkbox"/> mid-back pain / stiffness                          |  |
| <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> pain from front to back of chest                   |  |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> tension in shoulders                               |  |
|   | <input type="checkbox"/> pins & needles / numbness<br><u>specify where:</u> |  |

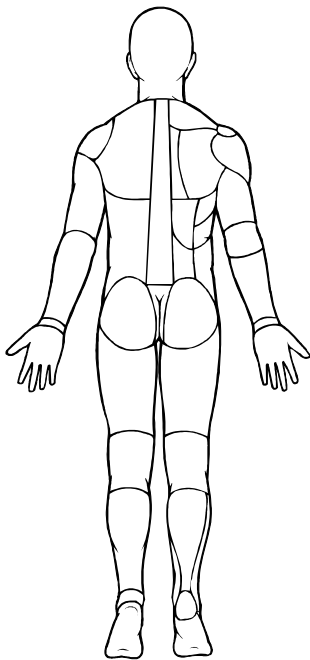
Signature \_\_\_\_\_

Date \_\_\_\_\_

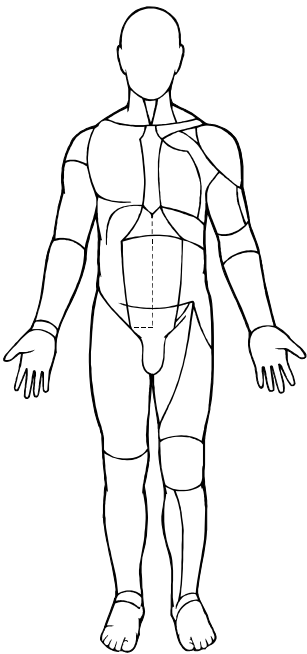
Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please circle your area of symptoms and indicate the type of symptom and its severity.



BACK



FRONT



LEFT



RIGHT

ACHE xxxxxxxx

STABBING //////////////

BURNING -----

PINS & NEEDLES :::::::::::

NUMBNESS ooooooooo

STIFFNESS \*\*\*\*\*

