CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! **Please complete all questions.** Thank you.

PLEASE PRINT Date:_____

Name:_____ Sex: M__ F__ Birth Date_____ Age_____
Address _____ City_____ Postal Code_____
Home Phone (___) _____Work Phone (____)_____ Mobile (___)_____
E-Mail Address_____ Occupation _____
Marital Status (circle one) M S W D CL Spouse's Name_____

Children's Names and Ages
1._____ Age_____
2._____ Age_____
3._____ Age_____
4._____ Age_____

Whom may we thank for referring you? _____
Favourite Hobbies and Interests:_____
List your chief complaints in order of priority:
1._____ For how long? _____
2._____ For how long? _____
3._____ For how long? _____
4._____ For how long? _____
Have you had same or similar problem(s) before? Yes___ No___
If so for how long? _____
Is this a result of an auto or work injury? Yes___ No___ If yes, when?_____
Give details_____
Medications you currently take:_____
_____
Other doctors you have seen for this problem:_____
_____

Have you ever been to a chiropractor before? Yes___ No___ If yes, when?_____
Surgeries you have had?_____
_____
Is there any chance that you are pregnant? Yes___ No___
Father, Mother, Brother, Sister, Children with similar problems? Yes___ No___
Give details_____
Do you have extended health insurance? Yes___ No___ Name of Company_____

The above information is true and accurate to the best of my knowledge.

_____ _____
Patient or Guardian Signature Date

Awakened Life Chiropractic & Wellness Center
Dr. Michael Coulas D.C
701 Rossland Rd. E, Suite 210
Whitby, ON L1N 8Y9
(905) 430-5352

Below is a list of diseases that may seem unrelated to the purpose of your chiropractic visit. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

___Pneumonia
___Rheumatic Fever
___Polio
___Tuberculosis
___Whooping Cough
___Anemia
___Measles
___Mumps
___Small Pox
___Chicken Pox
___Diabetes
___Cancer
___Heart Disease
___Thyroid
___Influenza
___Pleurisy
___Arthritis
___Epilepsy
___Mental Disorders
___Lumbago
___Eczema

INTAKE

___Coffee
___Tea
___Alcohol
___Cigarettes
___White Sugar

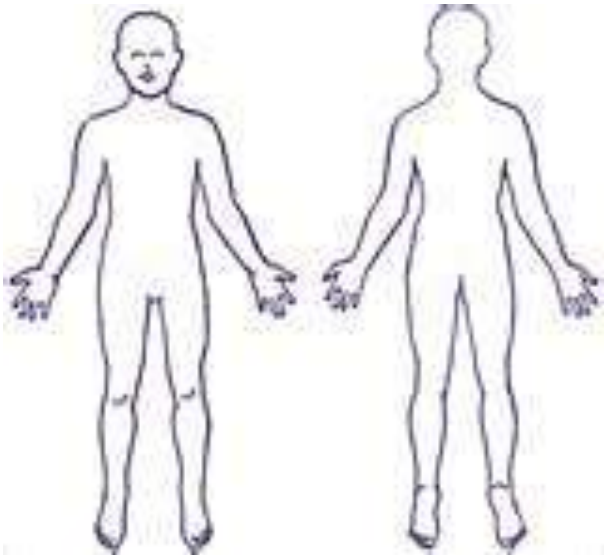
CHECK ANY OF THE FOLLOWING DISEASES THAT YOU HAVE HAD IN THE LAST SIX MONTHS

___Low Back Pain
___Pain between shoulders
___Neck Pain
___Arm Pain
___Joint Pain/Stiffness
___Walking Problems
___Difficult Chewing/Click Jaw
___General Stiffness
___Gas/Bloating after meals
___Heartburn
___Black/ Bloody Stool
___Colitis
___Prostate Sexual Disorders
___Other Problems
_____
_____

GENITO-URINARY CODE

___Bladder Trouble
___Painful/Excessive Urination
___Discoloured Urine

Please outline on the diagram the areas of discomfort



NERVOUS SYSTEM CODE

___Nervous
___Numbness
___Paralysis
___Dizziness
___Forgetfulness
___Confusion/Depression
___Fainting
___Convulsions
___Cold/Tingling
___Stress
___Chest Pain
___Short Breath
___Blood Pressure Problems
___Irregular Heartbeat
___Heart Problems
___Lung Problems
___Varicose Veins
___Ankle Swelling
___Stroke

GENERAL CODE

___Fatigue
___Allergies
___Loss of sleep
___Fever
___Headaches
___Vision Problems
___Dental Problems
___Sore Throat
___Earaches
___Hearing Difficulty
___Stuffed Nose

GASTROINTESTINAL CODE

___Poor/ Excessive Appetite
___Excessive Thirst
___Frequent Nausea
___Vomiting
___Diarrhea
___Abdominal Cramps
___Weight Trouble
___Gall Bladder Problems
___Constipation
___Hemorrhoids
___Liver Problems

FEMALES ONLY

When was your last period?

_____

Are you pregnant?

___YES ___NO
___Vaginal Pain/Infection
___Menstrual Irregularity
___Menstrual Cramps

MALE/FEMALE CODE

___Breast Pain/Lumps

FAMILY HISTORY

The following members have the same or similar problems as I do

___Mother
___Father
___Sister
___Brother
___Spouse
___Child

_____ _____

Patient Name **Date**