WEST NIAGARA CHIROPRACTIC & WELLNESS CENTRE

Dr. Megan West, D.C. **Dr. Anthony Varsalona, D.C.**
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www.wncwc.ca

Date: _____

Doctor: _____

Name: _____ Cellular Phone: _____

Home Address: _____ Home Phone: _____

_____ Business Phone: _____

Postal Code: _____ E-mail: _____

Your Occupation: _____

Date of Birth: _____ Age: _____ Sex: M/F

Do you have Insurance for Chiropractic care? NO YES

If so with whom: _____

How did you hear about our clinic?

Phone Book Sign Website Friend/Relative (Name):_____

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Medical Doctor (Name/City):_____

Chiropractic Care (Dr Name/City):_____

X-rays taken: Y / N Results: Excellent Good Fair

Have you ever been treated by an Osteopath, Physiotherapist, or Massage Therapist? Y / N

If so, who and when: _____

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Previous History	**Month/Year**	**Description**
Previous Falls/Injuries:		
Auto Accidents: "Ever"		
Serious Injuries: (i.e., head injury/dislocations/broken bones)		
Hospitalized:		
Surgeries: (Or recommended but not performed)		
Medications/Vitamins:		

Have you ever been knocked unconscious? Y / N If yes, for how long? _____

PATIENT: _____DOB:_____ M/F FILE:_____

Are you here because of a: Work related Injury? Yes/No Date of Injury_____
Auto Accident? Yes/No Date of Injury_____

What is your presenting complaint? _____

Where do you feel your symptoms? _____

What were you doing at the time of injury? _____

What makes your symptoms better/worse? _____ **Walking** _____ **Moving around/Exercise** _____ **Lying down**
(WRITE: B=better, W=worse) _____ **Standing** _____ **Bending forward** _____ **Inactivity**
_____ **Sitting** _____ **Bending backward** _____ **Nothing**

When did this start? _____ was it: **Gradual / Sudden**
Since your symptoms began is the pain: _____Getting worse _____Getting better _____Staying the same

How bad is your pain/ache? (Circle one) **0 1 2 3 4 5 6 7 8 9 10**
(NO PAIN) (SEVERE PAIN)

How frequent is your problem?

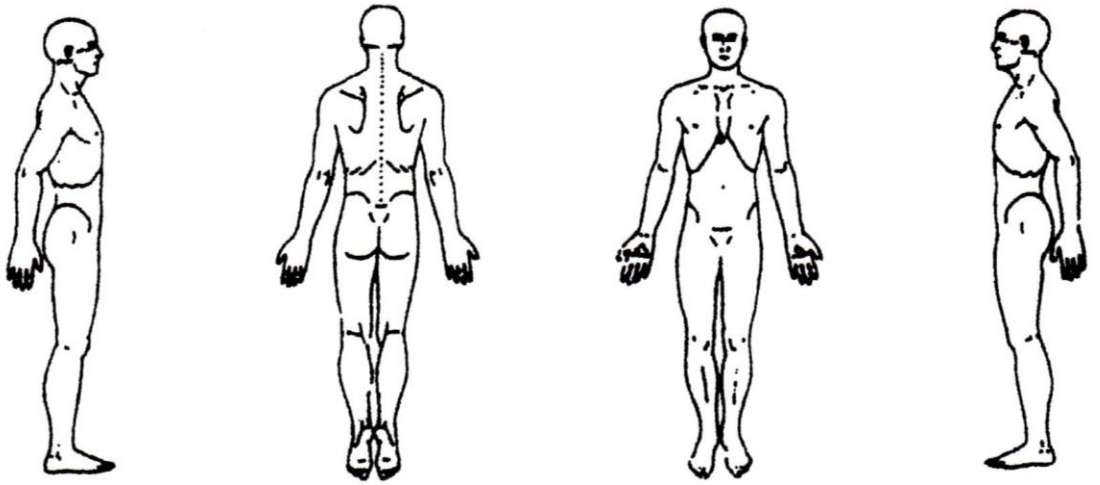
_____**constant (76-100%)** _____**frequent (51-75%)** _____**occasional (26-50%)** _____**intermittent (25% or less)**

Previous treatment for this condition _____

Home Treatment: _____**Ice** _____**Heat** _____**Stretches** _____**Nothing**

****

Indicate on the picture any areas of complaint – circle the best description for your symptoms



Achy
Dull
Sharp/Stabbing
Numbness
Pins/Needles
Throbbing
Shooting
Burning
Cramping
Stiffness
Swelling
Other_____
Patient Initial _____

Physical Activity at Work: _____Sitting more than 50% of workday ____Manual Labour
_____Light Manual Labour ____Heavy Manual Labour

General Physical Activity: ____ No regular exercise program ___ Light/ Strenuous exercise ___ Exercise Gym

Habits / Lifestyle:
How many hours of sleep do you get per night? **4 – 6 6 – 8 8 – 10 12 +** Do you wake rested? **Yes / No**
Handedness: **Right Left Both Height: _____ Wt. _____lbs.**

Tobacco, Caffeine, & Alcohol use:
Caffeine (cups/day):_____
Cigarette usage: non-smoker **never smoked** ☐ smoker **less than ½ pack/day** ☐
used to smoke ☐ **between 1 – 2 packs/day** ☐
more than 2 packs/day ☐
How many years have you smoked, or did you smoke before quitting? _____

PATIENT PAST HISTORY FORM

PATIENT: _____DOB:_____ M/F FILE:_____

Please check the appropriate box for any of the following symptoms, which you now have or have had previously.

NEUROLOGICAL

- ☐ allergy
- ☐ crying spells
- ☐ depression
- ☐ dizziness
- ☐ fainting
- ☐ fatigue
- ☐ fevers
- ☐ frequent anger
- ☐ headaches
- ☐ loss of sleep
- ☐ loss of weight
- ☐ nervousness
- ☐ night sweats
- ☐ numbness
- ☐ tremors/twitching

MUSCULAR-SKELETAL

- ☐ arthritis
- ☐ bursitis
- ☐ foot trouble
- ☐ grinding in neck
- ☐ hernia
- ☐ low back pain
- ☐ neck pain
- ☐ neck stiffness
- ☐ pain b/w shoulders
- ☐ tightness in shoulders
- ☐ weakness

PAIN OR NUMBNESS

- ☐ shoulders
- ☐ arms
- ☐ hands
- ☐ hips
- ☐ legs
- ☐ knees
- ☐ ankles
- ☐ feet
- ☐ cold hands/feet
- ☐ painful tail bone
- ☐ painful joints
- ☐ pins & needles in hands
- ☐ pins & needles in legs
- ☐ sciatica
- ☐ swollen joints

RESPIRATORY

- ☐ chest pain
- ☐ chronic cough
- ☐ difficulty breathing
- ☐ lung problems
- ☐ wheezing

CARDIO-VASCULAR

- ☐ hardening of arteries
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ pain over heart
- ☐ poor circulation
- ☐ previous heart trouble
- ☐ rapid heart beats
- ☐ slow heart beats
- ☐ strokes
- ☐ swelling of ankles
- ☐ varicose veins

GASTRO INTESTINAL

- ☐ belching or gas
- ☐ colitis
- ☐ colon trouble
- ☐ constipation
- ☐ diarrhea
- ☐ gall bladder trouble
- ☐ hemorrhoids
- ☐ liver trouble
- ☐ nausea
- ☐ poor appetite
- ☐ stomach pain/trouble
- ☐ vomiting

SKIN

- ☐ bruise easily
- ☐ eczema
- ☐ hives or allergy
- ☐ psoriasis
- ☐ skin rash
- ☐ sensitive skin

GENITO-URINARY

- ☐ bed wetting
- ☐ bladder infection
- ☐ blood in urine
- ☐ frequent urination
- ☐ inability to control urine
- ☐ kidney infection
- ☐ painful urination
- ☐ prostate trouble

CHILDHOOD CONDITIONS

- ☐ ear infections
- ☐ tubes in ears
- ☐ chronic illness

Pregnant at this time? Yes / No

Due Date: _____

Miscarriage:_____

Menopausal: Yes / No

Last Menstruation date: _____

Are you aware of having any of the following:

- ☐ aneurysm
- ☐ epilepsy
- ☐ heart cond./disease
- ☐ asthma
- ☐ excessive thirst
- ☐ osteoporosis
- ☐ respiratory cond.
- ☐ blurred vision
- ☐ pleurisy
- ☐ scoliosis
- ☐ cancer _____
- ☐ hepatitis
- ☐ pneumonia
- ☐ sinus/allergies
- ☐ diabetes
- ☐ HIV
- ☐ stroke
- ☐ thyroid