



Patient Intake Form – St. Andrew’s Chiropractic & Wellness

Dr. D. Carey Avery B Kin. D.C.

15570 Yonge St. Unit 5 ▪ Aurora, ON ▪ L4G 1P2

905-727-6500 ▪ www.standrewschiro.ca

Personal Information

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

Address: _____ Apt. # _____

City: _____ Postal Code: _____

Home Phone: _____ Work/Cell/Other Phone _____

e-mail: _____

Occupation: _____ Employed by: _____

Marital Status: _____ Name of Spouse: _____

Family Doctor/Number _____

How were you referred to Dr. Avery: _____

Does your insurance plan include Chiropractic?: Y / N If yes, what is your coverage limit \$ _____

Current Health History (please fill out all that applies to you)

Is this injury as a result of a Motor Vehicle Accident: Y / N

Is this a WSIB (work) Injury?: Y / N

Date of Injury: _____ Claim Number: _____ Policy Number: _____

Auto Insurance / WSIB Contact Name & Number: _____

Social Insurance Number: _____

Current Complaints (in order of importance to you):

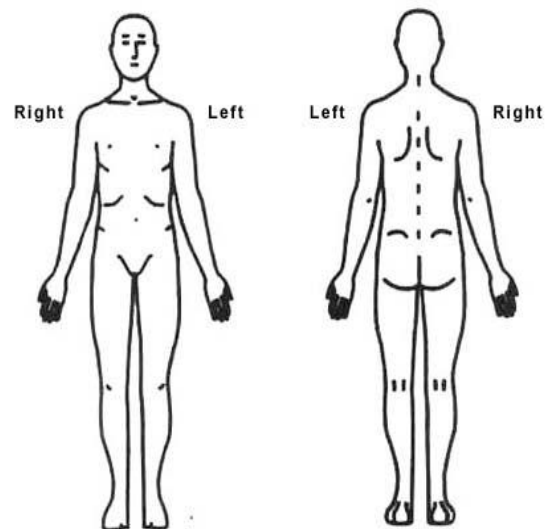
- 1. _____ pain level /10
- 2. _____ pain level /10
- 3. _____ pain level /10

What do you believe is wrong with you?: _____

Have you seen any other healthcare professionals before coming to this office?: _____

Have you ever had Chiropractic Treatment before: Y / N

If yes how long has it been since your last treatment: _____



MARK PAINFUL AREAS WITH AN "X"



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Health History Cont'd

Do you wear Orthotics?: Y / N If yes how old are they?: _____
Do you smoke?: Y / N If yes, Cigarettes/day _____ for _____ years
Do you drink?: Y / N If yes, glasses/week _____
Do you Exercise?: Y / N If yes, ___ times/week Type of Exercise: _____
Height: _____ Weight: _____
FEMALES ONLY: Are you pregnant? Y / N If yes, how many weeks pregnant are you?: _____

Family Health History (direct relations only parents, siblings and grandparents)

Name	Relation	Health Issue(s)

Personal Health History

Please list any Surgeries, Fractures or Major Traumas and the year they occurred:

General Health Information

Head & Neck

Headaches Neck Pain Sinusitis Hearing Problems Ringing in the Ears Vertigo/Dizziness Eye Problems Vision Problems
 Nose Problems TMJ (jaw pain) Sore Throat Voice Changes

Chest, Lung, Heart & Skin

Chest Pain Palpitations Blood Pressure Issues Asthma Allergies Insomnia Night Sweats Lung Problems
 Shortness of Breath Skin problems Bruise Easily

Internal, Digestive & Miscellaneous

Nausea Heartburn Poor Appetite Loss of taste Bloating Numbness Fainting Anxiety Depression
 Belching/Gas Diarrhea Constipation Abdominal Pain Liver Problems Kidney Problems Frequent Urination
 Urinary Tract Infections Painful Urination Prostate Trouble Incontinence Hemorrhoids Muscle Cramps Diabetes
 Nosebleeds Stiff Joints and muscles Low Energy Poor Appetite Scoliosis Poor Posture
 Other: _____

Gynecological (Females Only)

Congested Breasts Lumps in Breasts Cramps or Backache Irregular Cycle Excessive Menstrual Flow Endometriosis
 Hot Flashes Menopausal Symptoms Irregular Periods Painful Periods Absent Periods