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

Dr. D. Carey Avery B Kin. D.C.
14845 Yonge St. Unit 4 ▪ Aurora, ON ▪ L4G 6H8
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?:_____

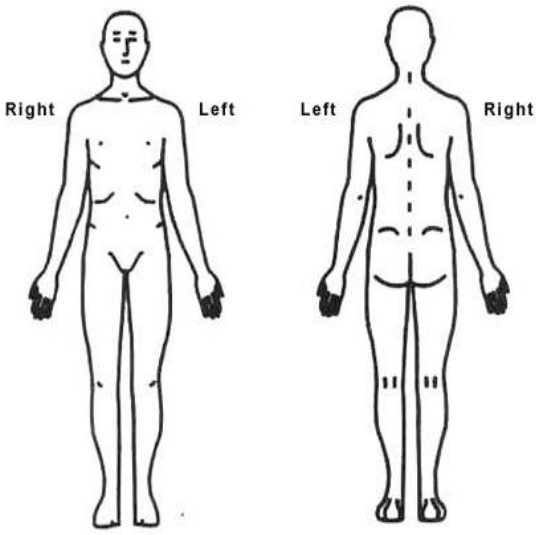
_____

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: **Current Medications**, **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 □Hemmorhoids □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