PATIENT INFORMATION FORM

Name: ___________________________________ Date: ____________________

Address: ____ City: ___________ Postal Code: ________

Phone: (H) ____________ (W) ____________ (C) ____________ Which # do you prefer we use? _____

Email Address: ________________________________ May we add you to our mail/email list? Y ___ N __

Date of Birth (dd/mm/yy): ____________ Gender: ______ Marital Status _________ # of Children ____

Occupation: ___________________________ Employer: ____________________________________

Emergency Contact Name and Phone Number: ____

Who may we thank for referring you to us? ____

HEALTH HISTORY

Did you have any childhood illnesses? ______ Explain: ____

Have you had any surgeries/hospitalizations? ____

Were you involved in any car accidents? _____ Explain: ____

Have you suffered any other physical trauma? ____

If this visit relates to a physical complaint: When did symptoms/accident happen? _____________________

Are you taking any medication? ______ If yes, list ____

Date of last physical examination ___________ Doctor's Name ________________________________

Have you seen a chiropractor before? ______ When was your last visit? ____________________________

Do you or any close family members suffer from any of the following?

- ❑ Allergies
- ❑ Aneurysm
- ❑ Arthritis
- ❑ Asthma
- ❑ Bloating
- ❑ Cancer
- ❑ Diabetes
- ❑ Disc prob.
- ❑ Epilepsy
- ❑ Fatigue
- ❑ Heart condition
- ❑ High Blood Press.
- ❑ Hormone imbal.
- ❑ Indigestion
- ❑ Intestinal disorder
- ❑ Osteoporosis
- ❑ P.M.S
- ❑ Respiratory Condition
- ❑ Stroke
- ❑ Skin Cond.
- ❑ Tendonitis/Bursitis
- ❑ Weak Immunity

The following can be signs of nervous system problems. Please check off all that you currently have or have previously experienced: (O = Occasional F= Frequent C= Constant)

O	F	C		O	F	C		O	F	C		O	F	C	
❑	❑	❑	Headaches	❑	❑	❑	Buzz/Ring in ears	❑	❑	❑	Problems urinating	❑	❑	❑	Nervousness
❑	❑	❑	Pins/Needles	❑	❑	❑	Visual problems	❑	❑	❑	Diarrhea/Constipation	❑	❑	❑	Irritability
❑	❑	❑	Dizziness/Fainting	❑	❑	❑	Loss of taste/smell	❑	❑	❑	Menstrual pain/Irreg	❑	❑	❑	Mood Swings
❑	❑	❑	Cold extremities	❑	❑	❑	Allergies/Asthma	❑	❑	❑	Sleep prob./Fatigue	❑	❑	❑	Depression
❑	❑	❑	Loss of balance	❑	❑	❑	Stomach Tension/Ulcer	❑	❑	❑	Neck/Back Pain	❑	❑	❑	Numbness

Dr. Alisa Blumberg – Pinewood Natural Health Centre
110-220 Duncan Mills Rd., Toronto, Ontario, M3B 3J5, (416) 656-8100, ablumberg@pinewoodhealth.ca

Patient Name:__________________

CURRENT HEALTH CONDITION

Purpose of this appointment (wellness/prevention/symptom relief)? Briefly describe ______________________

____

Compare this problem at its worst to when you feel great. How does it affect your ability to work? Your ability to enjoy your family and social time? Your ability to enjoy hobbies and sports?__________________________

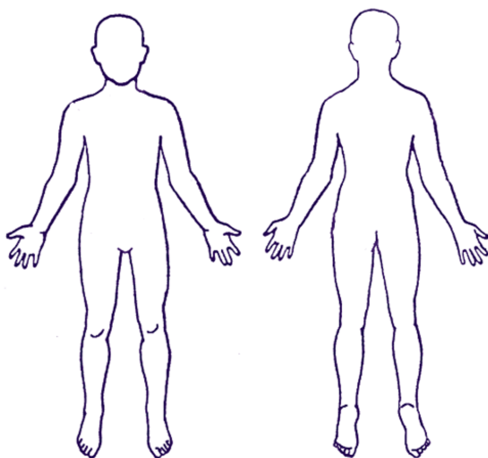
____

Have you ever had a similar condition? ______ If yes, when and describe: ______________________________

Why do you feel your body has not healed itself of this problem? __________________________________

Other doctors seen for this condition: ____

PHYSICAL WELLBEING



Please use the following letters to represent on the diagram the areas that bother you. (example, if your hand is numb put an N over the hand in the drawing)

N – numbness
P – pain
T – tingling
A – ache
S – soreness
ST - stiffness

Please rate your current discomfort by marking an X on the line below:

NONE ____WORST IMAGINABLE

Please rate your level of stress with an X on the line: NONE ____WORST IMAGINABLE

Please rate your level of happiness with an X on the line: NONE ____ HAPPIEST

Have you experienced psychological pain from feelings of depression, nervousness, irritability? _________

How many hours of sleep do you get per night? ____ Do you wake up feeling rested? _______

How many days per week do you meditate? _______

GOALS

Total wellness involves much more than physical health. Are there any areas/circumstances in your life in which you haven't yet achieved your goals (ex. relationship, financial)? ______________________________

____

Patient Name:___________________

CHEMICAL BALANCE

Speed of healing is determined by chemical balance in the body. Chemical balance is determined, in large part, by what you eat. Please indicate the amounts and frequencies you partake of the following (BE HONEST!):

	Per Day	Per Week
1. Coffee (caff/decaff)	____ cups	____ cups
2. Tea (herbal/regular)	____ cups	____ cups
3. Sugar, sweets, desserts, candy, artificial sweetner	____ times	____ times
4. Salt, salty snacks, chips, etc.	____ servings	____ servings
5. Do you add salt to food at mealtime?	____ yes ____ no	____ occasionally
6. Red meat (beef, pork, bacon, ham etc.)	____ servings	____ servings
7. Chicken/fish	____ servings	____ servings
8. Dairy (milk, cheese, ice cream etc.)	____ glasses/times	____ glasses/times
9. Water	____ glasses	____ glasses
10. Fresh fruit	____ servings	____ servings
11. Fresh vegetables (non-canned)	____ servings	____ servings
12. Alcoholic beverages	____ servings	____ servings
13. Soft drinks (caff/decaff)	____ servings	____ servings
14. Smoking	____ packs	____ packs

What is a typical breakfast for you? ____

What is a typical lunch for you? ____

What is a typical evening meal for you? ____

List any vitamins/herbs you are currently taking ____

Patient Name:___________________

INFORMED CONSENT TO CHIROPRACTIC EXAMINATION

Prior to establishing a treatment plan, an Examination must be performed in order to determine the cause of your complaint. During the examination, the doctor may perform some procedures or maneuvers intended to reproduce your symptoms, which will allow for a better understanding of the nature of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

By signing below, I consent to a chiropractic examination. Once a treatment plan is established, I will have the opportunity to discuss the treatment plan with my doctor and to consent to the proposed care.

Patient Signature: ____ Date: ________________________________

FEES POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that I will be financially responsible for all collection/legal fees incurred for the collection of any unpaid balance. I understand that a $25 fee may be applied to my account if I do not provide 24 hours notice of cancellation of my appointment.

Patient Signature: ____ Date: ________________________________

Dr. Alisa Blumberg – Pinewood Natural Health Centre
110-220 Duncan Mills Rd., Toronto, Ontario, M3B 3J5, (416) 656-8100, alisa@drblumberg.ca