Port Arthur Chiropractic Clinic
Dr. James DiGiuseppe
500 River Street
Thunder Bay, ON., P7A 3R8, (807) 345-9700

Name (As it appears on ID): _____ Date: _____

Address: _____ Postal Code: _____

Telephone: (Home): _____ (Business): _____ (Cell): _____

Email Address: _____ Date of Birth: _____

Sex: **M** **F** Occupation: _____

Marital Status: _____ Number of children: ____ Ages of children: _____

Previous Chiropractic Care: **Y** **N** Who: _____ When: _____

Family Physician: _____

How did you hear about our office? **Referral** **Yellow Pages** **Google** **Yelp** **Other**

Whom may we thank for referring you to us? _____

- Major complaint(s): _____
- Other complaints: _____
- How long have you had this condition? _____
- Is it getting: ○ Worse ○ Constant ○ Comes and goes ○ Better
- Previous health care professionals seen for present condition? _____
  When? _____
- Is this condition: ○ Work injury ○ Auto injury ○ Home/personal injury ○ Other
- Medication presently taking:
  ○ Painkiller ○ Anti-inflammatory/muscle relaxant ○ Nerve pills
  ○ Heart pills ○ Cholesterol ○ Other: _____
- Do you take **vitamins** or supplements? What? _____
- Have you had a **spinal x-ray, MRI,** or **CATSCAN?** What/When: _____
- Have you ever had major **surgery**? **Y** **N** Describe: _____
- Have you ever been injured in an auto accident? **Y** **N** Describe: _____
- Have you ever had any traumatic falls, accidents, fractures, concussions, etc.? **Y** **N**
  Describe: _____
- Do you have a regular **exercise** program? **Y** **N** What? _____
  Frequency: _____
- Are you pregnant? **Y** **N** **Unsure**

CHECK THE CONDITIONS FOR WHICH YOU HAVE OR HAD:

○ Asthma	○ High Blood Pressure	○ Irregular Painful Menstruation
○ Allergies	○ Stroke	○ Diabetes
○ Sinus Infection	○ Heart Disease	○ Gout
○ Pneumonia	○ Colon Disease	○ Multiple Sclerosis
○ Arthritis	○ Migraines	○ Eczema
○ Cancer	○ Infertility	○ Thyroid
○ Ulcers	○ Epilepsy	○ Other: _____

FAMILY HEALTH

Health problems are often hereditary; please list family members who have the above health problems.

Relation:	Heart Disease	Arthritis	Cancer	Diabetes	Other
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○

NUTRITIONAL/LIFESTYLE

Meals skipped: Daily _____ Weekly _____

Coffee daily: ○ 1-2 ○ 3-4 ○ 5+ ○ None

Alcohol daily: ○ 1-2 ○ 3+ ○ None Alcohol weekly: ○ 1-3 ○ 4-6 ○ 7+ ○ None

Personal satisfaction with food consumption:

○ Highly satisfied ○ Satisfied ○ Unsatisfied ○ Highly unsatisfied

What position do you sleep in? Select all that apply:

○ Side ○ Back ○ Stomach ○ Reclined

Do you smoke? Y N How many per day? _____

I would like chiropractic to help me (select all that apply):

○ Feel better ○ Increase daily function ○ Improve the quality of my life

INFORMED CONSENT TO EXAMINATION & X-RAY

I hereby request and consent to the performance of a Chiropractic, Orthopedic and Neurological examination and diagnostic x-rays (if required), which will determine if Chiropractic can help me. I understand that there is a very low risk of injury or aggravation from the examination procedures. These risks may include aggravation of pre-existing muscle strains, joint sprains or disc injuries and strokes.

Name (Please Print): _____

Signature: _____ **Date:** _____