DR. AMY HUNTER, B.SC., D.C.

www.kingswayjunctionchiropractic.com

TEL : 416 236 9919 FAX : 416 236 4243

KINGSWAY CHIROPRACTIC
In The Junction

DATE (MM/DD/YY) :

PATIENT INFROMATION

NAME : _____ DATE OF BIRTH (MMDDYY) : _____

SEX : MALE FEMALE (PLEASE CIRCLE ONE)

ADDRESS : _____

POSTAL CODE : _____

PHONE / CELL : _____

OCCUPATION : _____ EMPLOYER : _____

PREVIOUS FAMILY CHIROPRACTOR : _____ DATE LAST SEEN : _____

FAMILY PHYSICIAN : _____

REFERRED BY: INTERNET / FAMILY / FRIEND / OTHER _____

OFFICE USE :

DIAGNOSIS / CC :

PH : TRAMA

SURGERY / ILLNESS

LBP

HA

FAMILY HX :

MEDS :

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NAME : _____

DATE (MMDDYY) : _____

STANDING:

Forward flexion
Heel Stand _____/_____
Toe Stand _____/_____
S.I. _____/_____
Lumbar Kemps L_____R_____

GAIT ANALYSIS:

SENSATION/MOTOR:

Arm/Hand L_____R_____ B.P. _____
Leg/Foot L_____/_____R

REFLEXES/MOTOR:

B(5.6) _____/_____ T(6.7.8) _____/_____
BR (5.6) _____/_____ P (2.3.4) _____/_____
Ant.Tib (5) _____/_____ Plantar Flex (1) _____/_____
H (4.5.1.2) _____/_____ Ach (1.2) _____/_____

C/S:
ACTIVE ROM Comp _____ Traction _____

L_____/_____R Kemps L _____/_____R

SHOULDER: _____

ELBOW/WRIST/HAND: _____

SUPINE:

SLR L_____/_____R Braggard's L _____/_____R
Valsvalva
Fig. 4 L_____/_____R Leg Length
SI Comp L_____/_____R

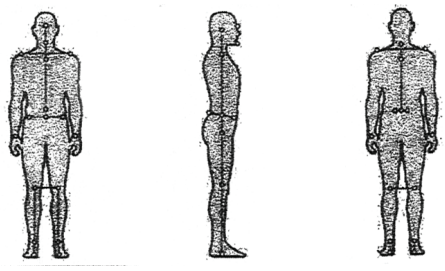
KNEE: _____

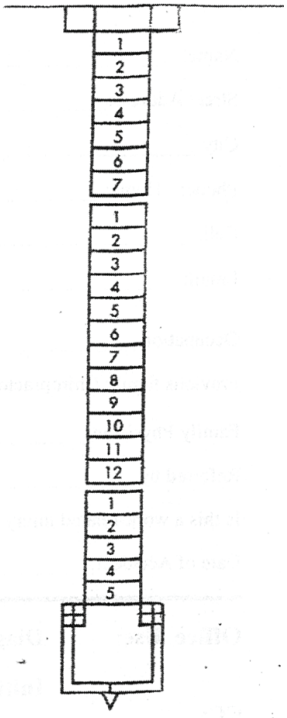
ANKLE/FOOT: _____

PRONE:

T/S and L/S Palp. _____

Posture Analysis





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HABITS AND LIFESTYLE

Do you smoke: yes _____ no _____

Do you consume alcohol: yes _____ no _____

Do you exersize: yes _____ no _____

Indoor activities: _____

Outdoor activties: _____

Do you wake rested? yes _____ no _____

Rate your sleep, hours per night: 4-6 6-8 8-10 12+

Rate your appetite: ***poor*** ***fair*** ***medium good*** ***excellent***

Rate your diet: ***poor*** ***fair*** ***medium good*** ***excellent***

Do you eat regularly ***(please circle all that apply):*** Breakfast Lunch Dinner

How many meals per day? 1 2 3 4+

Date of last dental exam: _____

Date of last physical exam: _____

Falls / Accidents - please list: _____

_____

Surgery / Operations - please list: _____

Do you take vitamins / minerals / supplements ? - please list: _____

_____

Medications / Drugs currently taking - please list: _____

_____

Have you been hospitalized in the last 12 months? yes _____ no _____

List reason: _____

Any new family health conditions/problems: yes _____ no _____

Please explain: _____

_____

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PATIENT PAST HISTORY FORM

Please X the appropriate line for any of the following symptoms which you have now or have had previously.

O = Occasional F = Frequent C = Constant

O F C

_ _ _ allergy
_ _ _ chills
_ _ _ convulsions
_ _ _ dizziness
_ _ _ fainting
_ _ _ fevers
_ _ _ headaches
_ _ _ loss of sleep
_ _ _ nervousness
_ _ _ depression
_ _ _ neuralgia
_ _ _ numbness
_ _ _ sweats
_ _ _ loss of weight
_ _ _ tremors

MUSCLE AND JOINT

_ _ _ arthritis
_ _ _ bursitis
_ _ _ foot trouble
_ _ _ hernia
_ _ _ low back pain
_ _ _ neck pain
_ _ _ neck stiffness
_ _ _ pain between shoulders

RESPIRATORY

_ _ _ chest pain
_ _ _ chronic cough
_ _ _ difficulty breathing
_ _ _ spitting blood
_ _ _ throat phlegm
_ _ _ wheezing

EYES, EARS, NOSE AND THROAT

_ _ _ frequent colds
_ _ _ crossed eyes
_ _ _ deafness
_ _ _ dental decay
_ _ _ asthma
_ _ _ ear aches
_ _ _ ear discharge
_ _ _ ear noises
_ _ _ sinus infection
_ _ _ enlarged glands

O F C

_ _ _ enlarged thyroid
_ _ _ sore throat
_ _ _ tonsillitis
_ _ _ eye pain
_ _ _ failing vision
_ _ _ far sighted
_ _ _ gum trouble
_ _ _ hay fever
_ _ _ hoarseness
_ _ _ nasal obstruction
_ _ _ near sighted
_ _ _ nosebleeds

CARDIO-VASCULAR

_ _ _ rapid heart beat
_ _ _ slow heart beat
_ _ _ swelling ankles
_ _ _ hardening arteries
_ _ _ high blood pressure
_ _ _ low blood pressure
_ _ _ pain over heart
_ _ _ poor circulation

GASTRO INTESTINAL

_ _ _ excessive hunger
_ _ _ burping/gas
_ _ _ liver trouble
_ _ _ colitis
_ _ _ colon trouble
_ _ _ constipation
_ _ _ diarrhea
_ _ _ difficult digestion
_ _ _ distension of abdomen
_ _ _ stomach pain
_ _ _ gall bladder problems
_ _ _ hemorrhoids
_ _ _ intestinal worms
_ _ _ jaundice
_ _ _ poor appetite
_ _ _ nausea
_ _ _ vomiting
_ _ _ vomit blood

SKIN

_ _ _ boils
_ _ _ bruise easily
_ _ _ dryness

O F C

_ _ _ hives/allergy
_ _ _ itching
_ _ _ skin rash
_ _ _ varicose veins

GENITO-URINARY

_ _ _ bed wetting
_ _ _ blood in urine
_ _ _ frequent urination
_ _ _ urine control loss
_ _ _ kidney infection
_ _ _ painful urination
_ _ _ prostrate trouble
_ _ _ pus in urine
_ _ _ smell of urine

PAIN OR NUMBNESS IN:

_ _ _ shoulders
_ _ _ arms
_ _ _ hands
_ _ _ hips
_ _ _ legs
_ _ _ knees
_ _ _ ankles
_ _ _ feet
_ _ _ painful tail bone
_ _ _ sciatica
_ _ _ swollen joints

FOR WOMEN ONLY

_ _ _ cramps
_ _ _ heavy flow
_ _ _ light flow
_ _ _ irregular cycle
_ _ _ painful cycle
_ _ _ discharge
_ _ _ sore breasts

MENOPAUSAL: yes _____ no _____

Last menstruation date: _____

Pregnant (please circle one): yes no

Due Date: _____

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PRECONSULATION GENERAL HEALTH QUESTIONNAIRE

Please check one of the following:

1. ❑ No problems at this time - would like a check-up.
2. ❑ I have a specific problem and I want to correct it and learn how to prevent it from happening in the future.
3. ❑ I have a specific problem and I want it corrected, nothing else.

Please answer the following questions:

4. What is your major complaint? _____

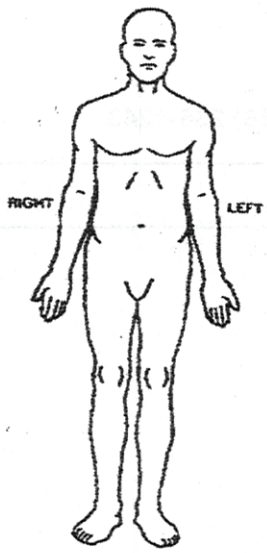
5. How long have you had this complaint? _____

6. How long has it been since you felt really well? _____

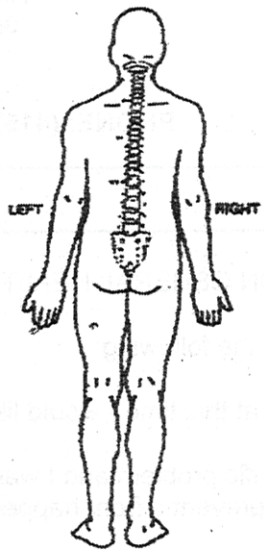
7. What do you believe is wrong with you? _____

8. Please mark areas of pain or injury on the illustration below and give a word description of the symptoms you are experiencing in those areas:

MARK AREAS OF PAIN



BURNING
STABBING
SHARP
DULL
TINGLING
NUMBNESS
STIFF
ACHE
THROBBING



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PRECONSULATION GENERAL HEALTH QUESTIONNAIRE (continued)

9. Is your condition: ❑ Getting better ❑ Getting wrose ❑ Other

10. Is your condition: ❑ Constant ❑ Comes and goes

11. Is the intensity of your pain: Mild Moderate Severe

12. Does the condition radiate to other areas of your body? NO YES Where?

13. What makes you feel worse:

- ❑ Sitting
- ❑ Walking
- ❑ Working
- ❑ Rest
- ❑ Standing
- ❑ Stairs
- ❑ Sneeze/Cough
- ❑ Medication
- ❑ Bending
- ❑ Driving
- ❑ Bowel movement
- ❑ Lifting
- ❑ Lying down
- ❑ Other _____

14. Any previous chiropractic care? ❑ NO ❑ YES Who/ Where? _____
When? _____

15. Sleep posture: ❑ Side ❑ Stomach ❑ Back

Other comments: _____