WARRINER CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

Date: ______________________ Health Card #: ______________________
number/ version code/ expiry date

Name: ______________________ Home Phone #: ______________________
(as it appears on OHIP card)

Address: ______________________ Work Phone #: ______________________

City/Prov: ______________________ E-mail: ______________________

Postal Code: ______________________ Marital Status: S M D W Sep

Birthdate: ______________ # of Children: ______________________
D M Y

Occupation: ______________________ Employer: ______________________

How did you find out about us? ______________________

Did your injury occur at work? ☐ Yes ☐ No

Is this injury a result of a motor vehicle accident? ☐ Yes ☐ No

Have you ever been under the care of a chiropractor? ☐ Yes ☐ No Name: ______________________

What brings you to our office today? Please list present complaints, symptoms or injuries, and when it began.

____

____

Are your symptoms:
☐ Getting worse ☐ Getting better ☐ Staying the same

List any doctors consulted for present symptoms:

____

____

____

____

How bad is your pain? Place an X on the scale below:

____
0 — 5 — 10
No pain — Unbearable pain

List any/all surgeries and/or fractures you have had:

____

____

____

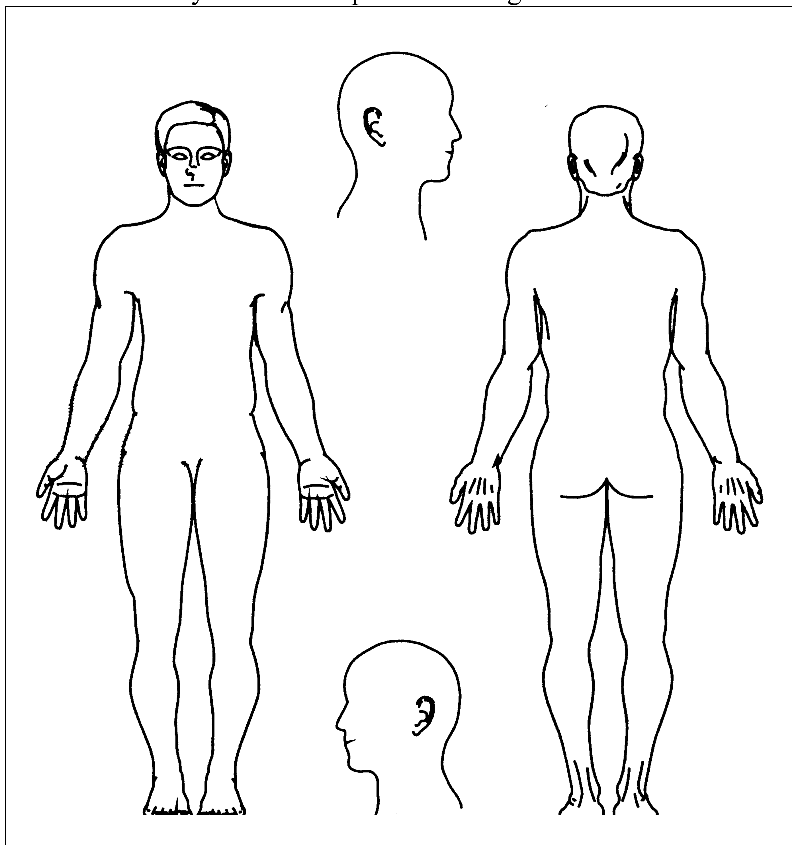
List former serious accidents, injuries or falls:

____

____

____

Please mark your areas of pain on the figures below:



CHECK ANY OF THE FOLLOWING THAT APPLY:

GENERAL SYMPTOMS

☐	Headache	☐	Fainting	☐	Fatigue	☐	Allergies
☐	Fever	☐	Dizziness	☐	Nervousness	☐	Wheezing
☐	Chills	☐	Convulsions	☐	Gain/Loss of Weight	☐	Neuralgia/Neuritis
☐	Sweats	☐	Loss of sleep	☐	Numbness/Pain in arms, hands, legs	☐	Depression

EYES, EARS, NOSE AND THROAT

☐	Failing Vision	☐	Eye Pain	☐	Nosebleeds	☐	Hayfever
☐	Nearsightedness	☐	Deafness	☐	Nasal Obstruction	☐	Tinnitus -ringing in ears
☐	Farsightedness	☐	Earache	☐	Sore Throat	☐	Asthma
☐	Crossed Eyes	☐	Ear Discharge	☐	Hoarseness	☐	Gum Trouble
☐	Frequent Colds	☐	Enlarged Thyroid	☐	Tonsillitis	☐	Sinus Infection
☐	Nasal Drainage	☐	Enlarged Glands				

SKIN

☐	Skin Eruptions	☐	Dryness	☐	Sensitive Skin	☐	Bruises Easily
☐	Itching	☐	Boils	☐	Hives or Allergies	☐	Varicose Veins

RESPIRATORY

☐	Chronic Cough	☐	Spitting up Phlegm	☐	Spitting up Blood	☐	Chest Pains
☐	Difficulty Breathing						

CARDIOVASCULAR

☐	Rapid Beating Heart	☐	Slow Beating Heart	☐	High Blood Pressure	☐	Low Blood Pressure
☐	Pain Over Heart	☐	Previous Heart Attack	☐	Hardening of Arteries	☐	Swelling of Ankles
☐	Poor Circulation	☐	Paralytic Stroke	☐	Aneurysm	☐	Murmur

MUSCLE & JOINT

☐	Stiff Neck	☐	Backache	☐	Swollen Joints	☐	Painful Tailbone
☐	Foot Trouble	☐	Pain in Shoulders	☐	Hernia	☐	Spinal Curvature
☐	Faulty Posture	☐	Arthritis				

GENITOURINARY

☐	Frequent Urination	☐	Painful Urination	☐	Blood in Urine	☐	Pus in Urine
☐	Kidney Infection	☐	Kidney Stones	☐	Bedwetting	☐	Prostate Trouble
☐	Inability to Control Urination						

GASTROINTESTINAL

☐	Poor Appetite	☐	Difficult Digestion	☐	Excessive Hunger	☐	Belching/Gas
☐	Nausea	☐	Vomiting	☐	Vomiting Blood	☐	Pain over Stomach
☐	Constipation	☐	Colon Trouble	☐	Hemorrhoids	☐	Intestinal Worms
☐	Liver Trouble	☐	Gallbladder Trouble	☐	Jaundice	☐	Colitis

FOR WOMEN ONLY

☐	Pregnancy	☐	Excessive Flow	☐	Menopausal Symptoms	☐	Irregular Cycle
☐	Lumps in Breast	☐	Previous Miscarriage	☐	Vaginal Discharge	☐	Congested Breast
☐	Hot Flashes	☐	Cramps or Backache	☐	Painful Menstruation		

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

☐	Appendicitis	☐	Scarlet Fever	☐	Diphtheria	☐	Typhoid Fever
☐	Pneumonia	☐	Rheumatic Fever	☐	Polio	☐	Malaria
☐	Tuberculosis	☐	Whooping Cough	☐	Anemia	☐	Measles
☐	Mumps	☐	Smallpox	☐	Chickenpox	☐	Diabetes
☐	Cancer	☐	Heart Disease	☐	Goiter	☐	Influenza
☐	Pleurisy	☐	Alcoholism	☐	Venereal Infection	☐	Epilepsy
☐	Mental Disorder	☐	Eczema	☐	Drug Dependency	☐	Emphysema
☐	Asthma	☐	High Cholesterol				

List any medications, and/or diet supplements you take:

____

____

Do you wear orthotics, heel or sole lifts? ____

Do your daily activities include mostly: ☐ Sitting ☐ Standing ☐ Lifting ☐ Other ________________

Do any other daily activities aggravate your present complaints? ______________________________

How would you rate your stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ High Stress

Physical activity level: ☐ No regular program ☐ Light exercise program ☐ Regular exercise program

Coffee, Tea, Caffeinated soft drinks (cups per day) ___________

Tobacco (packs per day) _____________

CONSENT TO CHIROPRACTIC SERVICES

CONSENT TO TREAT A MINOR CHILD:

I hereby authorize this office to administer chiropractic care as deemed necessary to my child.

Parent/Guardian Signature:_________________________ Date:_______________________

PAYMENT AND INSURANCE:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office may supply me with any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand that all services rendered me are charged directly to me, and that I am personally responsible for payment.

Patient Signature:_________________________________ Date: ______________________

Parent/Guardian Signature:_________________________ Date: ______________________

CONSENT TO CHIROPRACTIC SERVICES:

Chiropractors, Physicians, and Osteopaths are required to advise all patients that there is a risk of injury to the vertebral artery during the course of manipulative treatment of the cervical spine. This may cause strokes or stroke-like occurrences usually temporary in nature. The chance of this happening are between one in one million and one in one and a half million. Tests will be performed on you to minimize this risk. If x-rays are warranted you will be referred for them.

Chiropractic care is considered to be one of the safest and most effective forms of treatment. If you have any questions please consult your chiropractor.

I have read and understood the above statement, and consent to chiropractic treatment as required.

Patient Signature: ________________________________ Date: ______________________