Courtyard Chiropractic Health Centre

2863 Ellesmere Road, Suite 318
Toronto ON M1E 5E9
In the Dr.'s Offices of the Court Centenary Site of Scarborough and Rouge Hospital, SW corner of Ellesmere and Neilson Road

Practice Member Intake

416-724-7888 courtyardchiro.com

Patient Information

Last Name	First Name	Middle	Birth date MM DD YYYY

Health Card Number	Age	Gender ☐ M ☐ F ☐ NB	Email Address

Patient's Address

Street	Unit/Apt #	City	Province	Postal Code

How did you hear about us? ☐ Family/Friend/Colleague (Provide Name) _____
☐ Care Provider ☐ Google

Cell Number

Home Number	Name of Spouse	Name of Children

Employer	Occupation	Work Number

Family Doctor ☐ No ☐ Yes

Name of Doctor	Phone Number	Date of last visit MM DD YY	Date of last exam MM DD YY

Family Doctor's Address

Street	City	Province	Postal Code

Previous Chiropractor ☐ No ☐ Yes

Name of Chiropractor	Describe your experience	Date of last visit MM DD YY

Current Illness/Conditions

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone fracture
- ☐ Cancer
- ☐ Cirrhosis/hepatitis
- ☐ Degenerative disc/ joint disease
- ☐ Diabetes
- ☐ Dislocated joints
- ☐ Diverticulitis
- ☐ Epilepsy
- ☐ Fibroids
- ☐ Hay fever
- ☐ Heart condition
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney trouble
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Mental/emotional difficulty
- ☐ Multiple sclerosis
- ☐ Pacemaker
- ☐ Prostate trouble
- ☐ Respiratory
- ☐ Rheumatoid arthritis
- ☐ Scoliosis
- ☐ Sinus trouble
- ☐ Sleep problems
- ☐ STDs
- ☐ Stroke/TIA
- ☐ Swollen feet/legs
- ☐ Thyroid trouble
- ☐ Tired/achy legs
- ☐ Ulcer
- ☐ Varicose veins
- ☐ Venous insufficiency

Describe conditions and any others not listed:

Family History of Illness

- ☐ Alcoholism
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart condition
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Mental/emotional
- ☐ Osteoporosis
- ☐ Postural/feet
- ☐ Stroke/TIA

List relationship, illness, age of diagnosis, details

Lifestyle

Your current weight	Your height	Your ideal weight
☐ lbs ☐ kg	☐ in ☐ cm	☐ lbs ☐ kg

Alcohol	Cigarettes	Marijuana	Exercise
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes Hours per week: _____
Drinks per week: _____	Amount per day: _____	Describe use: _____	☐ Light ☐ Moderate ☐ Strenuous

Which of these 4 best describes your nutrition style?

☐ 1. I eat homecooked meals mostly. Check all that apply.
☐ Cultural/traditional: _____ ☐ Omnivorous/Everything ☐ Paleo/Keto ☐ Vegetarian ☐ Mediterranean
☐ Limiting carbs/calories ☐ Plant-rich including oil ☐ Whole food plant-based vegan (limited oil, sugar, salt)

☐ 2. I try to get some fruits, vegetables and salad daily, otherwise mostly packaged or fast food.

☐ 3. I eat anything and everything, mostly packaged or fast foods.

☐ 4. I am currently shifting my diet to something healthier. Describe.

Do you have a daily spiritual or mindset practice?

☐ No ☐ Yes, check all that apply ☐ Prayer ☐ Meditation ☐ Gratitude ☐ Journaling ☐ Accountability
☐ Online group/program ☐ Nature ☐ Yoga ☐ Goal-setting ☐ Affirmation ☐ Coaching
☐ Visualization ☐ Reading ☐ Other _____

Describe your lifestyle concerns and activity level:

Reasons for joining our practice

What are your major health goals and conditions you wish to improve?

☐ Custom Orthotics	☐ Muscle Tension	☐ Sciatica
☐ Extremity	☐ MVA/WSIB	☐ Spinal Maintenance
☐ Flexibility	☐ Nerve Symptoms	☐ Sports Performance
☐ Headache/Migraine	☐ Pain	☐ Stiffness
☐ Injury Rehab	☐ Posture	☐ Wellness

Describe your health goals

Further Systems Review

☐ Arteries hardening	☐ Diarrhea	☐ Hernia	☐ Poor circulation
☐ Bed wetting	☐ Dizziness	☐ Jaundice	☐ Prostate
☐ Bladder issues	☐ Dry skin/rashes	☐ Joint stiffness	☐ Swelling/lymph
☐ Bursitis	☐ Ear aches/noises	☐ Kidney infection	☐ Vertigo/dizziness
☐ Chest pain/rapid beats	☐ Excessive thirst	☐ Loss of control of urine	☐ Vomiting
☐ Colitis/irritable bowel	☐ Fainting	☐ Neuralgia/numbness/tingling	☐ Weight gain
☐ Constipation	☐ Gall bladder	☐ Painful urination	☐ Weight loss
☐ Depression/anxiety	☐ Gas/bloating	☐ Poor appetite	☐ Yeast infections

List any symptoms, health concerns or diagnoses not described elsewhere:

Surgeries list and approximate dates

Diagnostic Imaging and approximate dates (X-Ray, Ultrasound, CT, MRI)

Musculo-Skeletal-Neurological Symptoms

	Left	Right		Left	Right
☐ Neck	☐	☐	☐ Lower back	☐	☐
☐ Shoulder	☐	☐	☐ Hip	☐	☐
☐ Upper back/blades	☐	☐	☐ Buttock	☐	☐
☐ Upper arm	☐	☐	☐ Thigh	☐	☐
☐ Elbow	☐	☐	☐ Inner Knee	☐	☐
☐ Forearm	☐	☐	☐ Outer Knee	☐	☐
☐ Wrist/hand	☐	☐	☐ Lower leg	☐	☐
☐ Rib/side chest	☐	☐	☐ Ankle/foot	☐	☐

☐ Carpal tunnel syndrome
☐ Frozen shoulder
☐ Golfer's/tennis elbow
☐ Jaw pain/TMJ
☐ Neurologist visit
☐ Numb/tingling arms
☐ Numb/tingling legs
☐ Other specialist
☐ Pain/ache/burn
☐ Sciatica
☐ Skin hypersensitive
☐ Spasms
☐ Swelling
☐ Tendonitis
☐ Shoulder tension
☐ Visual disturbance

Describe previous diagnoses, specialists, locations and symptoms further (if applicable):

Sleep Posture and Habits

☐ Side sleeper ☐ Back sleeper ☐ Front sleeper ☐ Orthopedic pillow ☐ Well rested ☐ Fatigued

Describe sleep issues, pillow type/brand and mattress concerns (if applicable):

Ergonomics, Work and Play

Tell us what might be aggravating your current condition.

Hours @ computer/ games per day	Hours sitting	Hours standing	Rate stress ☐ High ☐ Moderate ☐ Low

☐ Heavy lifting ☐ Twisting/bending ☐ Phone cradled neck	"Self time" ☐ No ☐ Yes	Other factors

Describe stress, list hobbies, work/home issues and ergonomic challenges:

Supplements

High Quality Multivitamin ☐ No ☐ Yes	Mag/Vit D3 ☐ No ☐ Yes	Hormonal supplement ☐ No ☐ Yes	Glucosamine for joints ☐ No ☐ Yes
High Quality Omega 3 ☐ No ☐ Yes	Vitamin B12 ☐ No ☐ Yes	Other (list) ☐ No ☐ Yes _____	

Falls, Accidents, Hospital Visits, Medications

☐ Fall ☐ MVA ☐ Work Injury ☐ Emergency visit ☐ Hospitalization ☐ Unconsciousness ☐ Medications

Is this a workplace injury or motor vehicle collision claim? ☐ No ☐ Yes

List any conditions, recreational drug use, prescribed and/or OTC medications (length of use and dosages).

Women Only

Is there any chance that you might be pregnant? ☐ No ☐ Yes	☐ Cramps ☐ Irregular Cycle ☐ Discharge ☐ PMS ☐ Painful Cycle ☐ Pre/Menopausal

Describe symptoms, delivery due date and/or menopause experience/dates

Self-assessment

	Location 1	Location 2
Where are your symptoms?		
On a scale of 1-10, how intense is it now? (10 = worst)		
When did it start? Approximate date?		
How did it start? After or during which activities or events. Please describe.		
Have you had it before? If so, when?	☐ No ☐ Yes	☐ No ☐ Yes
For this episode, how often does it bother you/notice it? **CHECK ONLY ONE**	☐ Constantly ☐ 2-3/week ☐ Other: ☐ Daily ☐ 1/week _____ ☐ Most days ☐ 1/month	☐ Constantly ☐ 2-3/week ☐ Other: ☐ Daily ☐ 1/week _____ ☐ Most days ☐ 1/month
What does it feel like? **CHECK ALL THAT APPLY**	☐ Shooting ☐ Spasm ☐ Numb ☐ Sharp ☐ Tension ☐ Tingling ☐ Stabbing ☐ Throbbing ☐ Burning ☐ Dull ache ☐ Other: _____	☐ Shooting ☐ Spasm ☐ Numb ☐ Sharp ☐ Tension ☐ Tingling ☐ Stabbing ☐ Throbbing ☐ Burning ☐ Dull ache ☐ Other: _____
Does it travel from one place to another in your body?	☐ No ☐ Yes, describe where:	☐ No ☐ Yes, describe where:
What positions or activities make it feel worse? Sleep, work, etc.		
What positions or activities make it feel better? Stretch, walk, rest, stand, sit, etc.		
Have treatment, home care or other interventions helped? Please describe.	☐ No ☐ Yes	☐ No ☐ Yes

Please help your CCHC team help you, let us know how by checking all that apply

☐ Home exercise programs
☐ Massage therapy
☐ Custom orthotics
☐ Mindset workshops
☐ Compression stockings
☐ Online community
☐ Nutrition workshops
☐ Ergonomic tools/recommendations
☐ Supplement assessment and recommendations
☐ Support you in referring family, friends and/or co-workers

Do you have insurance that you want us to attempt direct billing to on your behalf? ☐ No ☐ Yes

On a scale of 1-10, how happy are you so far with your CCHC experience? (10 = best)

I have stated all conditions that I am aware of accurately and will inform CCHC of any changes to my contact information and status. All information on this form is strictly confidential and will become part of your chiropractic record. For more information, please refer to our Privacy Policy or contact us for more details.

Would you like to receive communications by email?

☐ I accept appointment e-reminders, e-statements and other e-communication.
☐ I do not want to communicate by email or receive e-reminders, e-statements, e-communication

Signature	Date MM DD YYYY

To avoid paying late cancellation and missed appointment fees, please provide the required notice:
Initial Assessments: 48 hours required | **Subsequent Visits:** 24 hours required