Courtyard Chiropractic Health Centre

Practice Member Intake 416-724-7888 courtyardchiro.com

Last Name:		■ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.	
First Name:	Middle:	Birth date: DD / MM / YY	
Email:		Age:	Gender:
Address & Unit:	City:	Postal Code:	
Cell#:	Health Card #:		
Home#:	How did you hear about us?		
Work#:	Employer:	Occupation:	
Spouse:	Children:		
Family Doctor: ☐ No ☐ Yes	Name of Doctor:	Ph:	
Address:	City:	Postal Code:	
Date of last Visit:	Date of last exam:		
Previous Chiropractor: ☐ No ☐ Yes	Name of Chiropractor:	Tel:	
Address:	City:	Postal Code:	
Date of last Visit:	Spinal X-Ray/Imaging History:		
Describe Chiropractic Experience:			

Current illness /Conditions: ☐ venous insufficiency ☐ varicose veins ☐ tired/achy legs ☐ swollen feet/legs ☐ lymphedema

☐ Allergies	☐ Cancer	☐ Heart Condition	☐ Multiple Sclerosis	☐ Degenerative disc / joint disease	
☐ Anemia	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Aneurysm	☐ Diabetes	☐ Rheumatoid Arthritis	☐ Prostate trouble	☐ High Cholesterol	☐ Respiratory
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ HIV/AIDS	☐ Ulcer	☐ Fibroids
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Sleep Problems	☐ Alcoholism
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐ Stroke/TIA

Describe conditions & list others:

Family History of illness:

☐ Alcoholism	☐ Cancer	☐ Heart Condition	☐ High blood pressure	☐ Mental/ Emotional	☐ Postural / Feet
☐ Arthritis	☐ Diabetes	☐ High Cholesterol	☐ Aneurysm	☐ Stroke/TIA	☐ Osteoporosis

List relationship, illness, age of diagnosis, details:

Lifestyle: Your current weight: lbs kg Your height: in cm Your ideal weight: lbs kg

Alcohol ☐ No ☐ Yes Drinks per day/wk:	Cigarettes ☐ No ☐ Yes Amt per day:	Caffeine ☐ No ☐ Yes Drinks per day:	Exercise ☐ No ☐ Yes Hrs per week: (Circle one) Light / Moderate / Strenuous

Describe your diet, lifestyle concerns & activity level:

Reasons for joining our practice: Your major health goals & conditions you wish improve.

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

Describe your current situation:

❑ 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: _____ Today's Date: DD / MM / YY

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.

Further Systems Review:			List any symptoms, health concerns or diagnoses not described elsewhere.		
☐ Dizziness	☐ Fainting	☐ Depression/Anxiety	☐ Yeast Infections	☐ Neuralgia/Numbness/Tingling	
☐ Bursitis	☐ Hernia	☐ Chest pain/rapid beats	☐ Ear aches/noises	☐ Swelling/lymph	☐ Jaundice
☐ Arteries hardening	☐ Poor circulation	☐ Colitis/Irritable bowel	☐ Gall bladder	☐ Poor appetite	☐ Vomiting
☐ Constipation	☐ Diarrhea	☐ Excessive thirst	☐ Gas/bloating	☐ Joint stiffness	☐ Bladder Dx
☐ Dry skin/rashes	☐ Bed wetting	☐ Loss of control of urine	☐ Kidney infection	☐ Painful urination	☐ Prostate

Describe conditions & list others:

Surgeries List & Approx Dates:

Women Only:			Is there *any chance* that you might be pregnant? ☐ No ■ Yes			
☐ Cramps	☐ PMS	☐ Irregular Cycle	☐ Painful Cycle	☐ Discharge	☐ Pregnant	☐ Pre/Menopausal

Describe symptoms; Delivery due date; Menopause experience/dates:

Musculo-Skeletal-Neurological Symptoms:				
☐ Wrist/hand R L	☐ Forearm R L	☐ Elbow R L	☐ Upper Arm R L	☐ Shoulder R L	
☐ Ankle/foot R L	☐ Lower leg R L	☐ Knee R L inner outer	☐ Thigh R L	☐ Hip R L	☐ Buttock R L
☐ Lower back R L	☐ Neck R L	☐ Upper back/blades R L	☐ Rib/side chest	☐ Tendonitis	☐ Spasms
☐ Visual disturbance	☐ Jaw pain/TMJ	☐ Numb/tingling legs or feet	☐ Sciatica	☐ Numb/tingling arms or hands	
☐ Swelling	☐ Skin hypersensitive	☐ Tension top of shoulders	☐ Pain/ache/burn	☐ Numbness/loss of feeling? Where?	
☐ Neurologist visit	☐ Other specialist	☐ Carpal Tunnel Syndrome	☐ Frozen shoulder	☐ Golfer's/Tennis Elbow	

Describe previous diagnoses, specialists, locations & symptoms further, if applicable:

Sleep Posture & Habits:					
☐ Side sleeper	☐ Back sleeper	☐ Front sleeper	☐ Orthopedic pillow	☐ Well rested	☐ Fatigued

Describe sleep issues & pillow type/brand, if applicable:

Ergonomics, Work & Play:	Consider what might be aggravating your current condition.			
Hours @ computer/games per day:	Hours sitting:	Hours standing:	☐ Heavy lifting	☐ Twisting/bending
Other factors:	☐ Phone cradled neck	Rate stress: ☐ high ☐ moderate ☐ low		"Self time" ☐ N ☐ Y

Describe stress, list hobbies, work issues, ergonomic challenges:

Supplements:					
High Quality Multivitamin ☐ No ☐ Yes	High Quality Omega 3 ☐ No ☐ Yes	Glucosamine for joints ☐ No ☐ Yes	Calcium/Mag/Vit D3 ☐ No ☐ Yes	Hormonal supplement ☐ No ☐ Yes	Other ☐ No ☐ Yes

Describe your supplements regimen:

Falls, Accidents, Hospital visits, Meds:	List any recreational drug use, prescribed or OTC medications; length of use, condition & dosages.				
☐ Fall	☐ MVA	☐ Work Accident	☐ Emergency visit	☐ Hospitalization	☐ Unconsciousness	☐ Medications

Drugs, conditions & dosages:

24 business hours notice required to cancel or change appointments.

WE LOOK FORWARD TO SERVING YOU, IN YOUR HEALTH JOURNEY

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

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