Krzyzelewski Chiropractic

Adult Patient Information

Name _____ Date _____

Address _____
Street City Province Postal Code

Sex: ☐ M ☐ F Age_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Manitoba Medical # _____ (6 digit) Personal Health ID # _____ (9 digit)

Birthdate _____ Spouse's Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

Occupation _____ Employer _____

Referred to our office by _____

Health Concerns bringing you into the clinic today:

Rate of Severity: 1 = mild to 10 = extreme

1. _____ Severity:_____ How long? _____

Is your pain: ☐ Dull ☐ Sharp ☐ Other Does it radiate anywhere? ☐ Yes ☐ No

If yes, where so?_____

What makes it worse? _____

What makes it better? _____

Does this condition interfere with any of the following: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Sports/Exercising

2. _____ Severity:_____ How long? _____

Is your pain: ☐ Dull ☐ Sharp ☐ Other Does it radiate anywhere? ☐ Yes ☐ No

If yes, where so?_____

What makes it worse? _____

What makes it better? _____

Does this condition interfere with any of the following: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Sports/Exercising

3. _____ Severity:_____ How long? _____

Is your pain: ☐ Dull ☐ Sharp ☐ Other Does it radiate anywhere? ☐ Yes ☐ No

If yes, where so?_____

What makes it worse? _____

What makes it better? _____

Does this condition interfere with any of the following: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Sports/Exercising

Have you sought other treatment for any of the above conditions? Was it of benefit? _____

_____

Due to the affects of stress on our health and ability to heal, in each category please list your top 3 stresses you have ever had:

1. Physical Stress (falls, accidents, work postures, etc.)
   A. _____
   B. _____
   C. _____
2. Bio-chemical Stress (smoke, unhealthy foods, missed meals, low water intake, drugs, alcohol, etc)
   A. _____
   B. _____
   C. _____
3. Psychological or Mental/Emotional Stress (work, finances, relationship, self-esteem, etc)
   A. _____
   B. _____
   C. _____

Please rate your current stress levels on a scale of 1 – 10: Work:_____ Home:_____ Play:_____

Please rate the following from 1 – 10 (1 being very poor and 10 being excellent):

Eating Habits:_____ Exercise Habits:_____ Sleep: _____ General Health:_____ Mind Set:_____

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs/Day_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day_____
☐ Heavy	☐ Heavy Labor		

Is there any other information which may help to better understand you, which has not been discussed? _____

_____

_____

_____

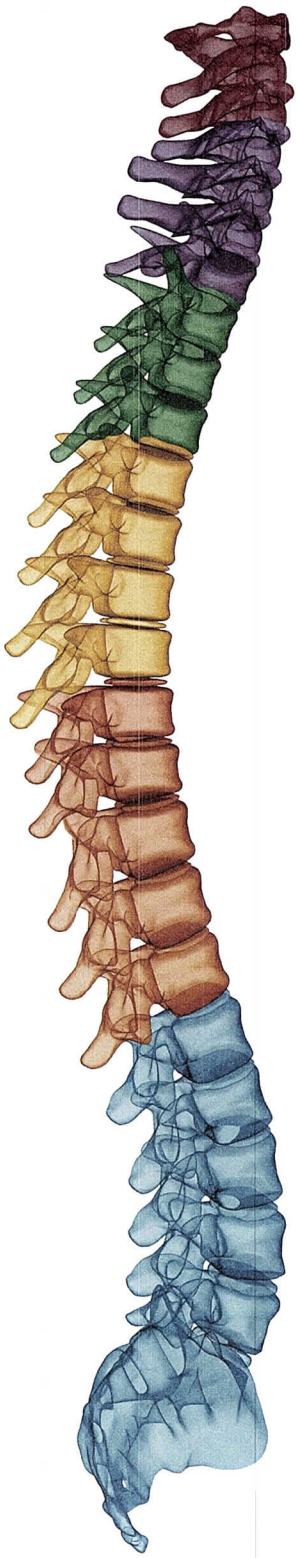
I understand that payment is due at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature _____ Date _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS (PAST / PRESENT)	
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	Colic & Excessive Crying Ear & Sinus Infections Allergies & Congestion Immune Deficiency Headaches & Migraines Vertigo & Dizziness Sore Throat & Strep Swollen Tonsils & Adenoids Vision & Hearing Issues Low Energy & Fatigue Difficulty Sleeping Pain, Numbness & Tingling in Arms to Hands	Epilepsy & Seizures Sensory & Spectrum ADD / ADHD Focus & Memory Issues Anxiety & Stress Balance & Coordination Speech Issues TMJ / Jaw Pain Stiff Neck & Shoulders Depression High Blood Pressure Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	Reflux / GERD Chronic Colds & Cough Asthma	Bronchitis & Pneumonia Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	Gallbladder Pain / Issues Jaundice Fever	Indigestion & Heartburn Stomach Pains & Ulcers Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	Behavior Issues Hyperactivity Chronic Fatigue Chronic Stress	Allergies & Eczema Skin Conditions / Rash Kidney Problems Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	Constipation Crohn's, Colitis & IBS Diarrhea Bed-wetting Bladder & Urination Issues Cramps & Menstrual Issues Cysts & Endometriosis Infertility Impotency Hemorrhoids	Sciatica & Radiating Pain Lumbopelvic / SI Joint Pain Hamstring Tightness Disc Degeneration Leg Weakness & Cramps Poor Circulation & Cold Feet Knee, Ankle & Foot Pain Weak Ankles & Arches Lower Back Pain Gluten & Casein Intolerance

Patient Name: _____ Date: ___/___/___