Baarbé Chiropractic Centre

Dr. Johannes Baarbé, B.P.E., B.Sc., D.C
99 King Street East, Bowmanville, ON L1C 1N4
Phone: (905) 623-7055 • Fax: (905) 623-7055 * 51

Date:	Patient No:

Personal History

Name: ________________ Address: ________________
City: ________________ Province: ________ Postal Code: ________
Home Phone: ________________ Birth Date: ________ Age: ______ Sex: ☐ M ☐ F
Extended Health Coverage: ________________ mm/dd/yyyy
Business / Employer: ________________ Type of Work: ________________
Business Phone: ________________ Name & No. of Emergency Contact: ________________
Relationship: ________________ Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Other
No. of Children: ___ Whom may we thank for referring you to this office? ________________
How will you primarily be taking care of your account? ☐ Cash ☐ Cheque ☐ Debit

Current Health Condition

Current Complaint(s): ________________

____

Have other doctors seen you for this condition: ☐ Yes ☐ No Who? ________________
Type of Treatment: ________________ Results: ________________
When did this condition begin? ________________ Has this condition occurred before? ☐ Yes ☐ No
Check the one that applies to your condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: ________
Date of Accident: ________________ Time of Accident: ________________
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Lying Down ☐ Cold ☐ Dampness
☐ Other: ________________
What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication ☐ Other: ________
What is the present progression of your condition? ☐ Getting Worse ☐ Staying the Same ☐ Coming and Going ☐ Getting Better
What is the character of your pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning ☐ Constant ☐ Intermittent
Please describe how it feels when this problem is at its worst: ________________

____

Please circle the grade indicating the severity of your pain: WORST 1 2 3 4 5 6 7 8 9 10 LEAST
Compare this problem at its worst and a time when you felt great.
How does this problem at its worst interfere with your work life? ________________
How does this problem at its worst interfere with your personal life? ________________
How does this problem at its worst interfere with your hobbies or sports? ________________
At its worst, how old does this problem make you feel? ________________
If you don't get this problem corrected do you think it will get worse over the next 5 years? ☐ Yes ☐ No
What drugs are you now taking? ☐ Nerve Pills ☐ Painkillers / Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin
☐ Other: ________________
Do you suffer from any condition other than that for which you are now consulting us? Explain. ________________

____

On a scale of 1 to 10, with 10 being the highest, rate your commitment to correct this problem: ________
Have you had X-rays taken in the last year? ☐ Yes ☐ No If yes, where? ________________

Past Health History

Please Check or Describe:
Major Surgery / Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery ☐ Broken Bones
☐ Other: ________________
Previous: Childhood Traumas: ☐ ________ Sports Injuries ☐ ________
Motor Vehicle Accidents: ☐ ________ Work Injuries ☐ ________
Hospitalization (other than above): ________________
Previous Chiropractic Care: ☐ None ☐ Doctor's name and approximate date of last visit: ________________

Family Health History

Does any member of your family suffer from the same condition: ☐ Yes ☐ No Whom? ________________
Have your children ever had a spinal check-up? ☐ Yes ☐ No If yes, where and when? ________________

____

____

Current Health Condition

Current Complaint(s): ________________

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema

Check any of the following you have had in the past six months

Musculo-Skeletal Code

- ☐ Low Back Pain
- ☐ Gas / Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black / Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain / Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing / Clicking Jaw
- ☐ General Stiffness

Nervous System Code

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

C-V-R Code

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems / Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

General Code

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT Code

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal Code

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

Male / Female Code

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

Genito-Urinary Code

- ☐ Bladder Trouble
- ☐ Painful Excessive Urination
- ☐ Discoloured Urine

Females Only

When was your last period? ____________

Are you pregnant?
☐Yes ☐ No ☐ Not Sure

Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Personal Satisfaction with Diet

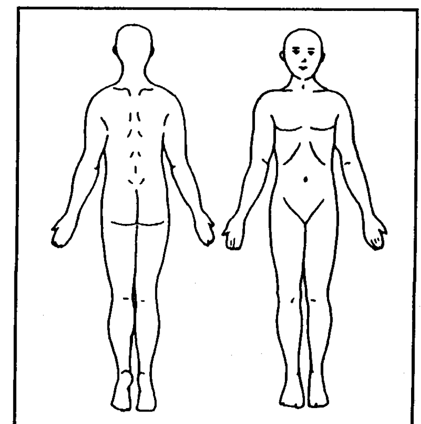
- ☐ Highly Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

- ☐ Yes
- ☐ No

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐Very Little



Please outline on the diagram the area of your discomfort and any radiation of pain.