PERSONAL and HEALTH INFORMATION – 1

Patient Name: _____ Patient Number: _____ Date: _____
(Day/Month/Year)

How would you like to be addressed? _____

Home Address: _____
No./ Street/Apt No./ City / Province/Country/ Postal Code

Phone: (Home):_____ (Work): _____ (Cell):_____ Email: _____

May we enroll you in our monthly Newsletter? _____

Occupation: _____ Employer: _____

Date of Birth: _____ Age: _____ Sex: Male ☐ Female ☐ Other ☐
Day/Month/Year

Marital Status: Single _____ Married _____ Divorced/Separated _____ Widowed _____ No. of children: _____

Emergency Contact: _____ _____
Name Phone

How did you hear about Dr. Paul Taillefer? _____

Family Doctor: _____ _____ _____
Name Phone Address

Date of last physical or visit to medical doctor (Day\Month\Year): _____

Date of last dental exam (Day\Month\Year): _____

Extended Coverage: Yes _____ No _____ Specify: _____
(eg. Blue Cross, Great West Life, SunLife, GSM, etc.)

Chief Complaint / Purpose of this Visit:

What is your goal in seeking chiropractic care with Dr. Paul ?

Is this a: (*Place a ✓ for all that apply*):

☐ Worker's Safety and Insurance Board (WSIB) Case

Date of accident _____ WSIB Claim No. _____ Have you made a report of your accident to your Employer? _____

☐ Motor Vehicle Accident (MVA) Date of accident _____ MVA Claim No. _____
Have you contacted your Insurance Company ? _____

Have you ever been to a chiropractor before? Yes _____ Date of last visit: _____ No _____

If Yes, for what condition(s)? _____

Reason for Leaving: _____

What was the result of your previous chiropractic treatment? _____

Were medical imaging tests done (X-rays, ultrasound, CT scan, MRI, etc) ? Yes _____ No _____

If Yes, on which body part(s)? _____

When was your last medical imaging test done (X-rays, ultrasound, CT scan, MRI, etc.)? _____
(Day\Month\Year)

Please list any *current or previous* significant **injury**, illness, **surgery,** accidents, falls, **trauma, fracture, car accidents**, **hospitalization, infections**, or other:

Date (dd/mm/yy)	

Please list any current or previous **medical conditions** and **treatments:**

Please list any **medications** , **vitamins / natural health products** that you are taking or have taken previously:

I, the undersigned, declare that the above information is correct and has been submitted to the best of my knowledge.

_____ _____
Patient Signature Date

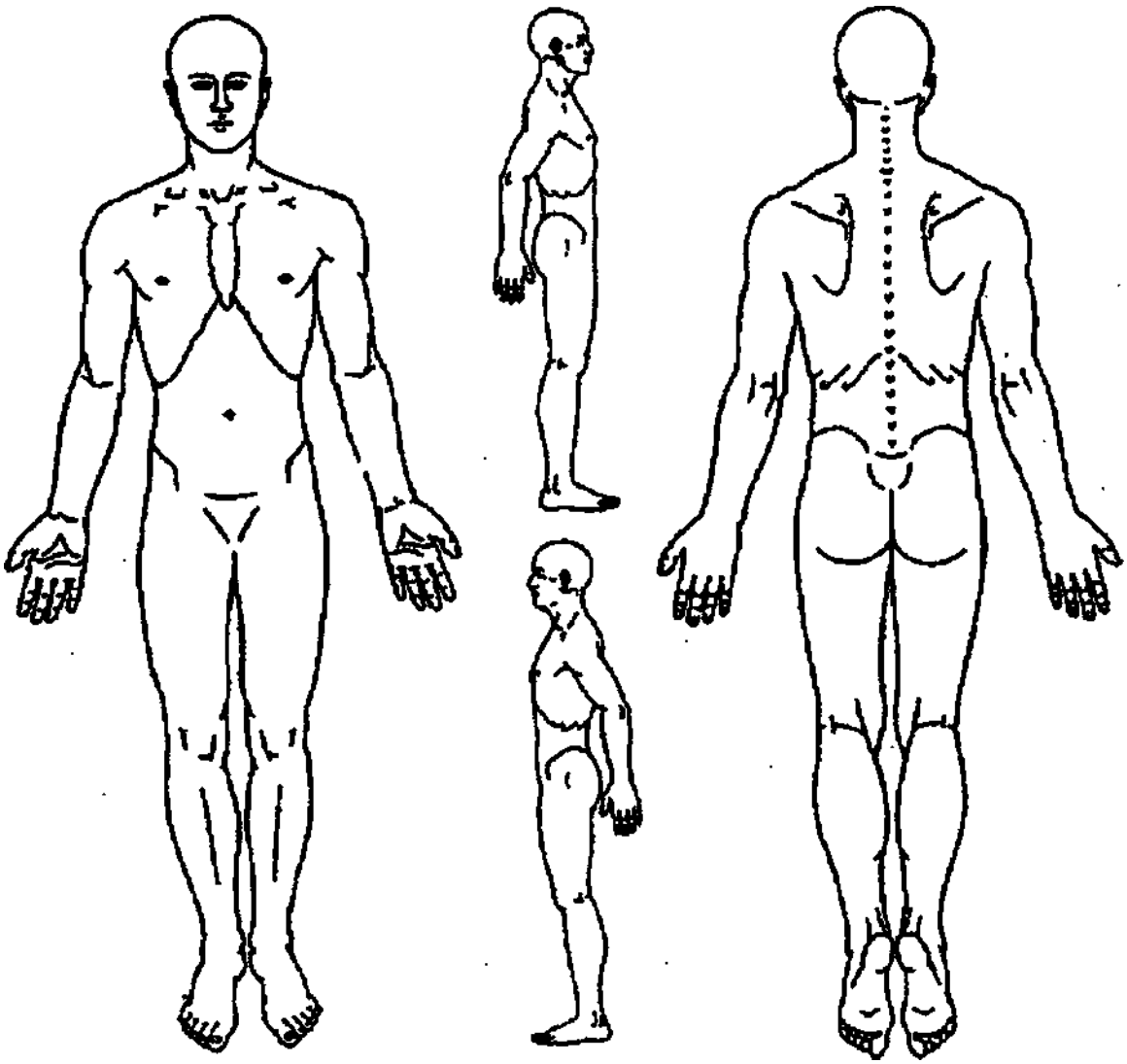
_____ _____
Doctor Signature Date

Patient Number: _____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location off your sensations.

Key: A-ACHE B-BURNING N-NUMBNESS
P-PINS & NEEDLES S-STABBING O - OTHER



For Clinic Use Only: Patient Number: _____

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Is there anything associated with the onset of this condition? Yes _____ No _____
If Yes, please explain. _____
When did this condition begin (onset) ? _____
How long does it last (duration) ? _____
Does it come and go? _____ If Yes, how often (frequency) ?_____
Does the pain travel to your arms/hands or legs/feet (radiation)? Yes _____ No _____
Does it hurt to cough, sneeze, strain or laugh (Valsalva) ? Yes _____ No _____
What makes the pain worse (aggravating) ? _____
What decreases the pain (relieving) ? _____

Have you had this condition before? Yes _____ No _____
If Yes, what was the outcome ? _____
Have you had any previous treatment for this particular condition ? Yes _____ No _____
If Yes, what was the outcome? _____
Since your condition started, please place a ✓ if the condition is : Same _____ Better _____ Worse _____
Do you have any other bone, joint or muscle problems ? Yes _____ No _____
If Yes, please explain_____
_____

ACTIVITIES DISCOMFORT SCALE

For each of the following activities, please place a checkmark **√** in the column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity):

	0	1	2	3	4
Activity	**Doesn't Hurt**	**Hurts a Little**	**Hurts Very Much**	**Almost Unbearable**	**Unbearable**
Walking					
Sitting					
Bending					
Standing					
Sleeping					
Lifting					
Running or Jogging					
Climbing Stairs					
Carrying					
Pushing or Pulling					
Driving					
Dressing					
Reading					
Watching TV					
Household Chores					
Gardening					
Sports					
Employment					
Other					
Totals					

Comments: _____

_____

_____

SCORE: _____ Patient Number: _____

PRESENT HEALTH: Are you presently affected by any of the following? (within past 6 months)
O – OCCASIONAL (Once in 6 months) **F – FREQUENT** (Monthly or weekly) **C – CONSTANT** (Daily)

Muscle and Joint	O	F	C
Back Pain			
Neck Pain			
Painful Tailbone			
Foot Trouble			
Shoulder Pain			
Hernia			
Spinal Curvature			
Faulty Posture			
Arthritis			
Elbow			
Wrist			
Hip			
Knee			
Ankle			
Other			
GENERAL	**O**	**F**	**C**
Fever/Chills/Sweat			
Fainting			
Convulsions			
Allergy			
Skin Problems			
Colds			
Tremors			
Loss of Balance			
Osteoporosis			
Unintended Weight Loss			
URINARY	O	F	C
Painful Urination			
Getting up at night to urinate			
Increased Urination			
Blood in Urine			
Kidney / Bladder Infections			
Prostate Trouble			

GASTROINTESTINAL	O	F	C
Difficult Digestion			
Belching or Gas			
Nausea or Vomiting			
Pain Over Stomach			
Constipation			
Colon Trouble			
Liver Trouble			
Gall Bladder Trouble			
Heartburn			
Diarrhea			
Bloody Stool			
Irritable Bowel			
STRESS	**O**	**F**	**C**
Headache / Migraine			
Dizziness			
Numbness, pins, needles to extremities			
Ringing in Ears			
Loss of Sleep			
Loss of Concentration / Memory			
Irritability / Nervousness			
Depression			
Decreased Energy / Fatigue			
Tension			
RESPIRATORY	**O**	**F**	**C**
Chronic Cough			
Spitting up Phlegm / Blood			
Chest Pain			
Difficulty Breathing			
Bronchitis			

CARDIOVASCULAR	O	F	C
Rapid Heart Beat			
Slow Heart Beat			
High Blood Pressure			
Low Blood Pressure			
Pain Over Heart			
Swelling of Ankles			
	Yes	No	
Heart Disease			
Previous Heart Attack			
Poor Circulation			
Previous Stroke			
Angina			
High Cholesterol			
Past Heart Surgery			
FEMALES ONLY			
Painful Menstruation			
Excessive Flow			
Irregular Flow			
Cramps or Backache			
Abnormal Discharge			
Post Menopausal			
Are you Pregnant ?			
Birth Control Pill			
Miscarriages			
If yes, # of miscarriages			
Date of Last Menstrual Period	M	D	Y
EYES, EARS, NOSE, THROAT	O	F	C
Hearing Loss			
Earache			
Sore Throat			
Tonsilitis			
Sinus Trouble			
Visual Disturbances			

PAST HEALTH: Have you ever suffered from any of the following conditions?	Yes	No		Yes	No
Thyroid Nodule			Stomach Ulcers		
Diabetes			Emotional Problems		
Allergies			Epileptic Seizures		
Unusual Bleeding			Asthma		
Tuberculosis			Cancer		
Pneumonia			Polio		
Infectious Skin Conditions			Psoriasis		
Alcohol Use Disorder			Venereal Disease		
Hepatitis			HIV		

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