



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

P-PINS & NEEDLES

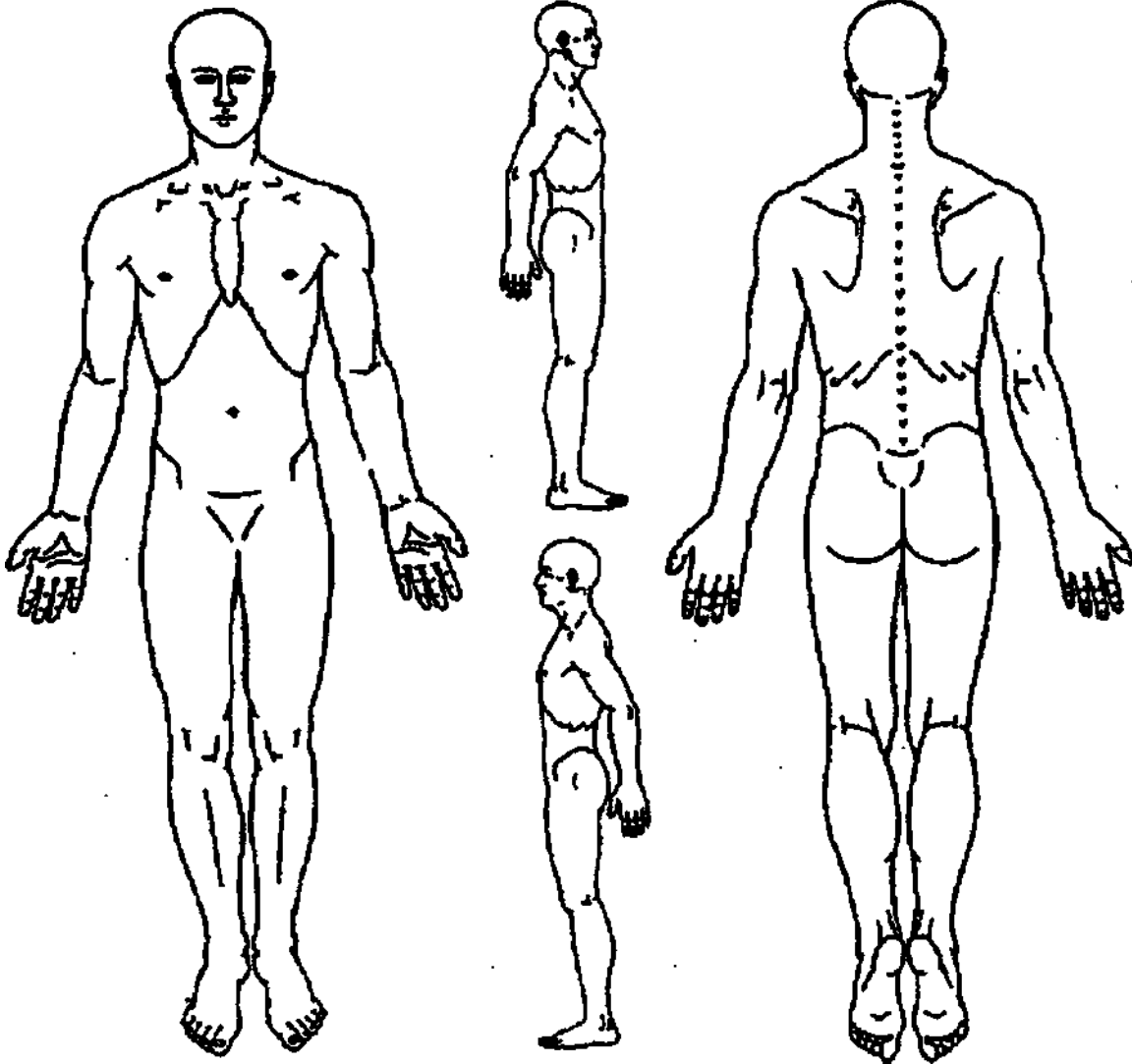
B-BURNING

S-STABBING

N-NUMBNESS

S-STIFFNESS

O-OTHER



For Clinic Use Only: Patient Number: _____



Is there any activity 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? Yes _____ No _____

Does it hurt to cough, sneeze, strain or laugh? Yes _____ No _____

What makes the pain worse (aggravating) ? _____

What decreases the pain (relieving) ? _____

Pain intensity (from 1-10 with 10 being the worst) Today _____ At worst _____

Have you had this condition before? Yes _____ No _____

Did you have treatment for this condition ? Yes _____ No _____

If Yes, what was the treatment and 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 _____

Are there any other symptoms associated with the onset of this condition? 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 | | | | | |

Lifestyle (Diet and Exercise): _____

Tobacco Cannabis Alcohol - Current Use Past Use

Years of use/ Quantity per day: _____

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 | | | |
| Loss of Appetite | | | |
| | | | |
| STRESS | O | F | C |
| Headache / Migraine | | | |
| Dizziness | | | |
| Numbness, pins, needles to extremities | | | |
| Ringin 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 |
| Tooth Trouble | | | |
| Hearing Loss | | | |
| Earache | | | |
| Sore Throat | | | |
| Tonsillitis | | | |
| Sinus Trouble | | | |
| Visual Disturbances | | | |

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

Family History of Cancer/ Cardiovascular Disease/Diabetes/ Arthritis/ Other: _____

Patient Number: _____