

Chelmsford Chiropractic



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Date of Visit (D/M/Y) ___/___/___ Sex: M F Marital Status S M D W
Name _____ Date of Birth (D/M/Y) ___/___/___ Age ____
 Last *Middle* *First*
Address _____ City _____ Postal Code _____
Phone (Home) _____ Phone (Cell) _____ Email _____
Occupation _____ Employer _____ Phone (Work) _____
Who referred you to the clinic? Family Physician Family/Friend Self Other _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: Name _____ Relationship to Patient _____
Phone (Home) _____ Phone (Cell) _____ (Work) _____
Family Physician: _____ Phone: _____

REASON FOR TODAY'S APPOINTMENT

Major Complaint(s)? 1) _____ 2) _____ 3) _____
How long have you had this complaint? _____
Since the onset of my symptoms (pain), my condition has? Improved Gotten Worse Stayed the Same
Have you been treated recently for this condition? Yes No If yes, by whom? _____
Is your injury due to? Car Accident Work Injury Other _____

HEALTH INSURANCE INFORMATION

Do you have extended health care benefits? Y N Do you have coverage for chiropractic care? Y N
EHC/Insurance Company _____ Phone: _____
Policy Number: _____ Member ID Number: _____ Division Number _____
Policy Holder's Name: _____ Relationship to Patient? Self Spouse Mother Father

WSIB Information

Claim Number: _____
Adjudicator: _____ Phone: _____

Auto Accident Information

Policy Number: _____
Insurance Co. _____ Phone: _____

PAIN DIAGRAM

Patient Name: _____ Date: _____

Instructions:

Below is a diagram of a body, front and back. Please use the symbols below to mark on the diagram where you feel your symptoms. After completing this diagram, please answer the questions below.

xxx Dull Achy

=== Numbness

^^^ Pins/Needles

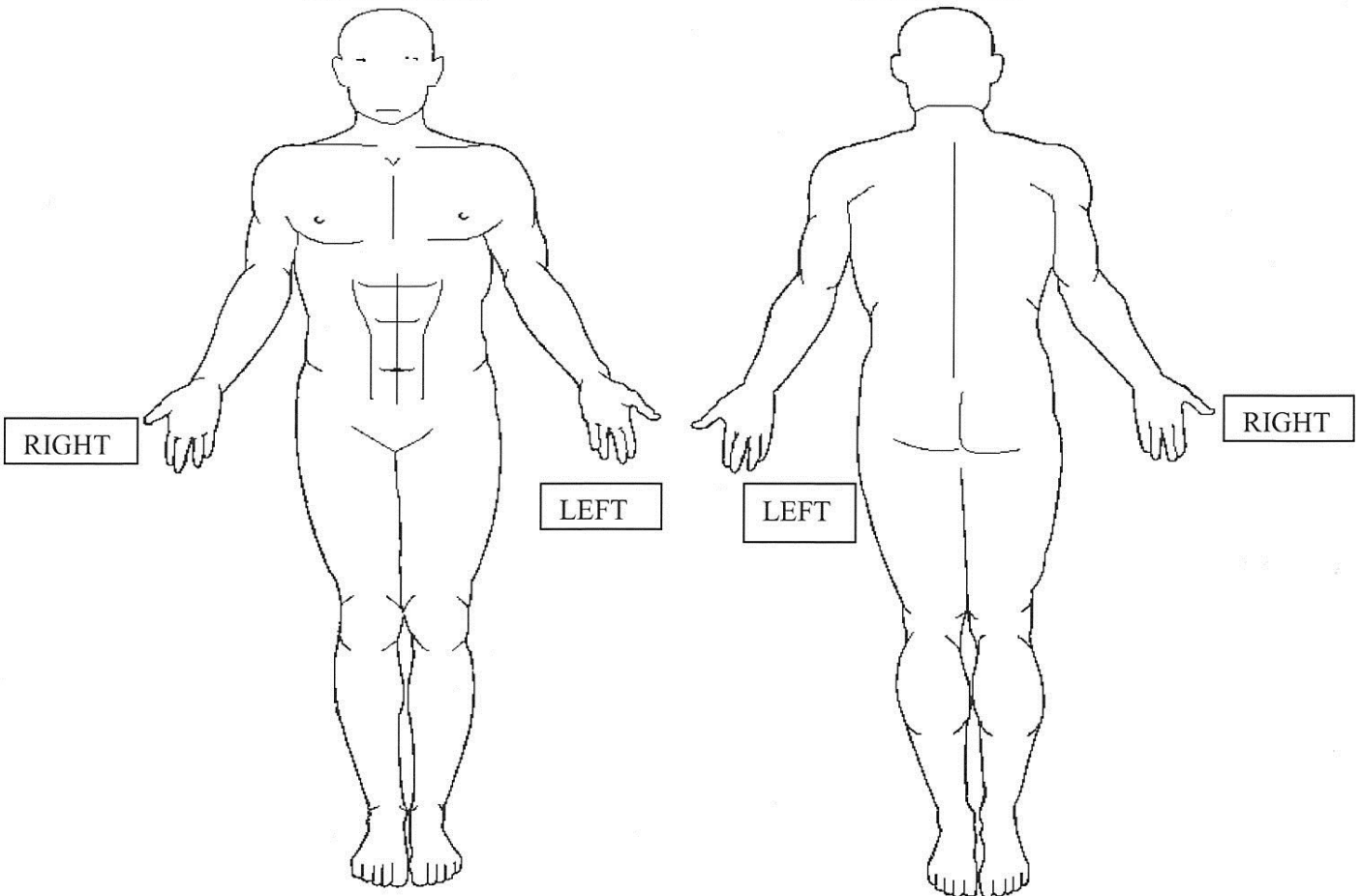
/// Sharp/Stabbing

000 Stiffness

□□□ Other _____

FRONT

BACK



On a scale of 0-10 (10 being the worst), mark with a single line (/) your current level of pain

0 (NO PAIN)



10(WORSE)

PERSONAL HEALTH HISTORY

Current Medications? _____

Past Hospitalizations/Surgeries? _____

Past Car Accidents/Trauma? _____

Do you smoke? Yes No If yes, how many packs/day? _____

Do you drink alcohol? Yes No If yes, how much/week? _____

Please check the following conditions that apply to you. Add any comments to clarify condition.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Feet Pain | <input type="checkbox"/> Headache/Migraine | <input type="checkbox"/> Muscle Cramps/Spasm | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Calf/Leg Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke/Aneurysm |
| <input type="checkbox"/> Fatigue/Weakness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Poor Circulation/Bruising | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Rheumatoid Arthritis | _____ |

LIFESTYLE HISTORY

What is your level of exercise? Daily 2-3 Times/Week Once/Week Once/Month Rarely

What activity do you do most on a daily basis? Sit Walk Stand Lift Other? _____

Do you take any vitamins/mineral supplementation? _____

How much water do you consume on a daily basis? _____

Hobbies/Sports/Recreation? _____

FAMILY HEALTH HISTORY

Please check any of the following if anyone in your immediate family has or has had any of the following conditions (mother, father, siblings, grandmother, grandfather). Add any comments to clarify condition.

- | | | | |
|---|-------|---|-------|
| <input type="checkbox"/> Cancer | _____ | <input type="checkbox"/> Rheumatoid Arthritis | _____ |
| <input type="checkbox"/> Heart Disease | _____ | <input type="checkbox"/> High Cholesterol | _____ |
| <input type="checkbox"/> Stroke/ Aneurysm | _____ | <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Other | _____ |

AUTHORIZATION OF CARE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine and/or joints of the extremities as well as manual therapies to the associated soft tissue structures, as he or she deems appropriate I clearly understand and agree that I am responsible for all bills incurred at the time of treatment rendered. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services will become immediately due and payable.

Patient Signature

Date