TILLSONBURG
CHIROPRACTIC
AND WELLNESS

DR. FATIMA KORAH
10 Brock Street East, Tillsonburg ON N4G 1Z5
Phone: (226) 641-5155 • Fax: (226) 641-5156
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PATIENT INFORMATION

Name: _____ Address: _____

City : _____ Province: _____ Postal Code: _____

Home Phone: _____ Birth Date: _____/_____/_____ (mm/dd/yy) Gender: _____

Cell Phone: _____ Email Address: _____

Occupation: _____ Business/Employer: _____

Marital Status _____ Number of Children: _____

Family Doctor: _____ Family Doctor's Location: _____

Health Card Number : _____

How did you hear about our office: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to Patient: _____

Phone Number: _____

OFFICE POLICIES

Please Initial Below

_____ I agree to the DC's discussing with other health practitioners at Tillsonburg Chiropractic and Wellness health concerns related to my chief complaint

_____ I agree to the DC releasing proof of attendance and payment information to 3rd party benefit and insurance companies

_____ I consent to the DC's performing a physical examination to further evaluate my case

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MEDICAL HISTORY

CURRENT HEALTH CONDITIONS

Current Complaint(s): _____

Other doctors seen for this condition? ___ Yes ____ No If Yes, Who? _____

Type of Treatment: _____ Results? _____

When did this condition begin? _____ Has this condition occurred before? _____ Yes _____ No

What aggravates your condition? Check all that apply Sitting ____ Standing ___ Bending ___ Lifting ___ Walking ___

Lying Down ___ Cold _____ Dampness _____ Other _____

What relieves your condition? Check all that apply: Bed Rest ____ Ice ____ Heat ____ Massage ____ Medication ____

Other _____

Is it getting: Worse ____ Constant _____ Better ____ Comes and Goes _____

Character of Pain: Sharp _____ Dull _____ Ache _____Numb _____ Burning _____ Pins and Needles _____

Please describe the problem at its worst:

_____

_____

When the problem is at its worst, does it interfere with: Your ability to work? Y _____ N _____

Your ability to enjoy family/social time? Y _____ N _____ Your ability to enjoy sports or hobbies? Y _____ N _____

If it isn't corrected, do you think this will get worse over the next 5 years? Yes _____ No _____

Medications you take now (check all that apply):

Cortisone _____ Prednisone _____ Steroid _____ Nerve pills _____ Insulin _____ Pain Killers _____

Muscle Relaxant _____ Blood Pressure Medication _____ Other: _____

Do You suffer from any other condition(s) other than that for which you are consulting us now? Yes _____ No _____

If yes, please describe: _____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____

Have you had x-rays taken in the last 6 months? Yes ____ No _____ If yes, where? _____

PAST HEALTH HISTORY

Height: _____ Weight: _____

Major Surgery/Operations: Hip Replacements ____ Knee Replacements _____ Fractures _____ Hernia _____

Shoulder surgery_____ Other _____

Major Accidents (MVA) or falls:_____

Hospitalization/Infectious Disease (other than for above):_____

Previous Chiropractic care: None _____ Doctor's name and approximate date of last visit:_____

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FAMILY HEALTH HISTORY

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

Please check off ALL of the following you have EVER had even if you don't think they are related to your current problem:

_____Low Back Pain
_____Gas/bloating/heartburn
_____Neck/Arm/Shoulder pain
_____Colitis/Irritable Bowel Syndrome
_____Joint Pain/Stiffness
_____Walking Problems
_____Difficulty Chewing/Clicking Jaw
_____General Stiffness
_____Nervous/Stress
_____Dizziness
_____Confusion/Depression/Forgetful
_____Fainting/Convulsions
_____Heart Problems
_____Cold/Tingling/Numbness
_____Chest Pain/Shortness of Breath
_____Blood Pressure Problems
_____Stroke
_____Lung Problems/Congestion
_____Varicose Veins/Ankle Swelling
_____Fatigue
_____Allergies
_____Fever
_____Headaches
_____Loss of Sleep
_____Vision Problems
_____Sore Throat/Ear Aches
_____ Stuffed Nose

_____Frequent Nausea/Vomiting
_____ Diarrhea
_____ Constipation
_____ Hemorrhoids
_____ Liver Problems
_____ Gall Bladder Problems
_____ Abdominal Cramping
_____ Menstrual Irregularity/Cramping
_____ Miscarriage(s)
_____ Breast Pain/Lumps
_____ Prostate/Sexual Dysfunction
_____ Cancer

INTAKE
_____ Coffee
_____ Tea
_____ Alcohol
_____ Cigarettes
_____ White Sugar

SATISFACTION WITH DIET
_____ Highly satisfied
_____ Somewhat satisfied
_____ Dissatisfied

FEMALES

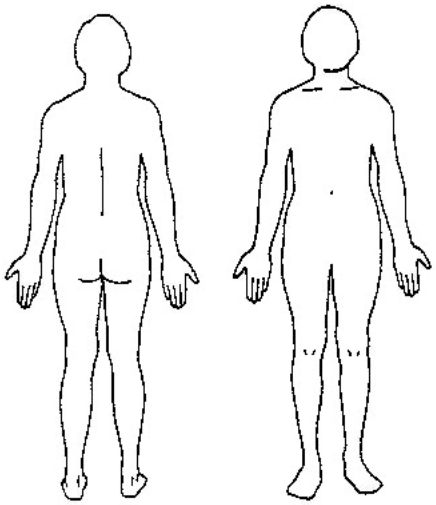
When was your last period?

_____

Are you Pregnant?

_____ Yes _____ No
_____ Unsure _____ Trying

PLEASE OUTLINE ON THE DIAGRAM THE AREAS OF YOUR DISCOMFORT AND ANY RADIATION OF PAIN



Everyday stressors (0 being none, 10 being the worst possible)

- Please rate your current everyday stress level

  No stress 0 1 2 3 4 5 6 7 8 9 10 absolute worst stress

- Please rate your work stress level

  No stress 0 1 2 3 4 5 6 7 8 9 10 absolute worst stress

- Self Perceived Posture

  Perfect 0 1 2 3 4 5 6 7 8 9 10 absolute worst posture

Amount of hours spent at a desk for work or leisure purposes in a day: 10+ _____ 7-9 _____ 5-7 _____ 3-4 _____ Less than 2 _____