New Life Chiropractic

Dr. Matthew Tonnos
279 Kerman Ave
Grimsby, ON L3M 3W3

CONFIDENTIAL PATIENT HEALTH RECORD

PERSONAL INFORMATION

Name_____ Date_____
Address_____ City _____ Postal Code _____
Home Phone _____Business Phone _____Cellular/Other_____
E-mail _____ Date of Birth ____ / ____ / ____ Age _____ Sex ☐ M ☐ F
(Month / Day / Year)
Occupation or Profession _____ Employer _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Name of Spouse _____ Number of Children _____
Whom shall we thank for referring you to our office? _____
Reason for consulting our office today: _____
_____

YOUR HEALTH PROFILE

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health. On a daily basis we experience multiple stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your well being.

The Beginning Years (To Age 17)

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Unsure
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐
Were you involved in any car accidents?	☐	☐	☐

	Yes	No	Unsure
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

Were you delivered: Naturally ☐ C-Section ☐ Forceps ☐
Vacuum ☐ Mom Induced ☐ Unsure ☐

Adult Years (Age 18 to present)

	Yes	No
Do/Did you smoke?	☐	☐
Do/did you drink any alcohol?	☐	☐
Have you been in any accidents?	☐	☐
If so was your nerve system checked by a Chiropractor afterwards?	☐	☐
Have you had any surgery??	☐	☐

For what? _____

	Yes	No
Do/did you participate in extreme sports?	☐	☐
Do/did you play contact sports?	☐	☐
If so did you have your spine and nerve system checked regularly by a chiropractor?	☐	☐

On a scale of 1-10 rate your stress level (1-none, 10-severe)

Occupational stress _____ Personal stress _____

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

O – Occasional F-Frequent C-Constant

	O	F	C
MUSCLE AND JOINT			
Backache	☐	☐	☐
Neck Pain	☐	☐	☐
Painful Tailbone	☐	☐	☐
Foot Trouble	☐	☐	☐
Shoulder Pain	☐	☐	☐
Hernia	☐	☐	☐
Spinal Curvature	☐	☐	☐
Faulty Posture	☐	☐	☐
Arthritis	☐	☐	☐
STRESS SYMPTOMS			
Headache/Migraine	☐	☐	☐
Dizziness	☐	☐	☐
Numbness or pins & needles in arms/hands, legs/feet	☐	☐	☐
Ringing in ears	☐	☐	☐
Blurring of vision	☐	☐	☐
Loss of sleep	☐	☐	☐
Loss of concentration/memory	☐	☐	☐
Irritable/Nervousness	☐	☐	☐
Depression	☐	☐	☐
Decreased energy/fatigue	☐	☐	☐
Tension	☐	☐	☐

	O	F	C
GENERAL SYMPTOMS			
Fever/Chills/Sweat	☐	☐	☐
Fainting	☐	☐	☐
Convulsions	☐	☐	☐
Allergy	☐	☐	☐
Skin Problems	☐	☐	☐
Colds	☐	☐	☐
Tremors	☐	☐	☐
Loss of balance	☐	☐	☐
RESPIRATORY			
Chronic cough	☐	☐	☐
Spitting up phlegm/blood	☐	☐	☐
Chest pain	☐	☐	☐
Difficult breathing	☐	☐	☐
URINARY			
Painful urination	☐	☐	☐
Getting up at night to urinate	☐	☐	☐
Blood in urine	☐	☐	☐
Increased urination	Yes ☐	No ☐	

	O	F	C
GASTROINTESTIONAL			
Difficult digestion	☐	☐	☐
Belching or gas	☐	☐	☐
Nausea or vomiting	☐	☐	☐
Pain over stomach	☐	☐	☐
Constipation	☐	☐	☐
Colon trouble	☐	☐	☐
Liver trouble	☐	☐	☐
Gall bladder trouble	☐	☐	☐
Heartburn	☐	☐	☐
Diarrhea	☐	☐	☐
Bloody stools	☐	☐	☐
EYES, EARS, NOSE, THROAT			
Deafness	☐	☐	☐
Earache	☐	☐	☐
Sore throat	☐	☐	☐
Asthma	☐	☐	☐
Tonsillitis	☐	☐	☐
Sinus trouble	☐	☐	☐

	O	F	C
CARDIOVASCULAR			
Rapid heart beat	☐	☐	☐
Slow heart beat	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Pain over heart	☐	☐	☐
Swelling of ankles	☐	☐	☐
Previous heart attack	Yes ☐	No ☐	
Poor circulation	Yes ☐	No ☐	
Previous stroke	Yes ☐	No ☐	
FEMALES ONLY			
Painful menstruation	Yes ☐	No ☐	
Excessive flow	Yes ☐	No ☐	
Irregular	Yes ☐	No ☐	
Cramps or backache	Yes ☐	No ☐	
Abnormal discharge	Yes ☐	No ☐	
Passed menopause	Yes ☐	No ☐	
Are you pregnant	Yes ☐	No ☐	
Birth control pill	Yes ☐	No ☐	

No. of miscarriages _____

Date of last menstrual period

_____

If you have no specific symptoms or complaints, and are here mainly for wellness services, please check (x) here ____ and skip to the box below. Those who have symptoms or complaints need to briefly describe the **chief** area of complaint, including the affect it has had on your life.

_____

_____

If you are experiencing pain, is it:

Sharp ☐ Dull ☐ Comes & Goes ☐ Travels ☐ Constant ☐

Since the problem started, it is: About the Same ☐ Getting Better ☐ Getting Worse ☐

What makes it worse: _____

It interferes with:

Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure ☐

Name of other Doctors seen for this problem:

Chiropractor _____

Medical Doctor _____

Other _____

Please list any significant illnesses, operations, accidents, falls, traumas and also medications.

Date	

INFORMED CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

Physicians, Osteopaths, Physiotherapists and Chiropractors are required to inform patients of both the benefits and rare potential for risk associated with care. Extremely rare incidents of sprain/strain, rib fracture, disc herniation and injury to the vertebral artery causing stroke or stroke like occurrences have been reported. The chances of this happening are reported to be less than one in 6-10 million. Chiropractic is considered to be one of the safest and most effective forms of care for the entire spine. If you read the above statement and consent to treatment/examinations/x-rays, please sign.

Print Name _____ Witness _____

Signature _____ Date _____

Thank you for completing this form. We certainly hope that we can help you attain optimal health.