

Listro Chiropractic Clinic
111 Redpath Ave., Toronto, Ontario M4S 2J9
WELCOME TO OUR OFFICE

CONFIDENTIAL PATIENT HEALTH RECORD

PERSONAL INFORMATION

Name _____ Home Phone _____
Address _____ City _____ Postal Code _____
Age _____ Birthdate _____ Marital: M S W D How many children? _____
Occupation _____ Employer _____
Work Address _____ Work Phone _____
EMail Address _____ Cell Phone: _____
Name and Number of Emergency Contact _____
Referred By _____

CURRENT HEALTH CONDITION

Main Purpose of this Appointment _____
When did this condition begin? _____ Has this condition occurred before? Yes No
Is Condition: Workmen's Compensation Board Motor Vehicle Accident
Date of Accident _____ Have you made a report to your employer?(if WCB) Yes No
What aggravates your condition? Sitting Standing Bending Lifting Walking Other _____
What relieves you condition? Bed Rest Ice Heat Massage Medication Other _____
Is condition? Getting Worse Constant Comes/Goes Getting Better
What medication or drugs are you taking? _____
Height _____ Weight _____ Shoe Size _____
Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

PAST HEALTH HISTORY

Date of last physical examination _____ Surgery/Operations _____
Serious Illnesses _____ Accidents/Falls _____
Have you had x-rays in last six months? Yes No If Yes, where _____
Have you ever been under Chiropractic Care? Yes No Doctor's Name _____

FAMILY HEALTH HISTORY

Does any member of the family suffer from same condition? Yes No If Yes, whom _____
Have your children ever had a spinal checkup? Yes No If Yes, where and when _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain between Shoulders
- Neck Pain
- Arm Pain
- Walking Problems
- Difficult Chewing/Clicking Jaw

- Gas/Bloating after meals
- Heartburn
- Black/bloody stool
- Colitis

FEMALES:
Are you pregnant?
 Yes No Not Sure

- GENITO-URINARY CODE**
- Bladder trouble
 - Painful/Excessive urination
 - Discolored urine

NERVOUS SYSTEM CODE

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- Epilepsy

- C-V-R CODE**
- Chest Pain
 - Short Breath
 - Asthma
 - Blood Pressure problems
 - Irregular Heartbeat
 - Lung Problems/Congestion
 - Varicose Veins
 - Ankle Swelling
 - Stroke

- GASTRO-INTESTINAL CODE**
- Poor/Excessive Appetite
 - Excessive Thirst
 - Frequent Nausea
 - Vomiting
 - Diarrhea
 - Constipation
 - Hemorrhoids
 - Liver Problems
 - Gall Bladder Problems
 - Weight Trouble
 - Abdominal Cramps

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

- EENT CODE**
- Vision Problems
 - Dental Problems
 - Sore Throat
 - Ear Aches
 - Hearing Difficulty

- MALE/FEMALE CODE**
- Menstrual Irregularity
 - Menstrual Cramping
 - Vaginal Pain/Lumps
 - Breast Pain/Lumps
 - Prostate/Sexual Dysfunction

DO YOU HAVE A REGULAR EXERCISE PROGRAM? Yes No

DO YOU TAKE VITAMINS? Yes No

LIFESTYLE STRESS LEVELS
 High
 Moderate
 Very Little

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, his prepared recommendation is an incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Preventative Care Corrective Care Relief Care Check here if you want the doctor to select the type of care appropriate for your condition.

PLEASE READ CAREFULLY:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's Signature X _____ Date _____