Dr. Navdeep Toor, BSc,DC,RMT | Phone: 647.740.8417
9983 Keele Street (Suite 104), Maple, Ontario, L6A 3Y5
WWW.BACKTOBASICS.CARE

CHIROPRACTIC CARE INTAKE FORM

Please tell us about yourself:

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr.

Full Name: _____

Date of birth: _____ (day, month, year)

Address: _____

Phone Number: _____

Email Address: _____

Occupation: _____ Employer/Business Name: _____

How did you hear about the office? _____

Emergency Contact Name & Number:_____

PREVIOUS CHIROPRACTIC EXPERIENCE

Previous Chiropractor's Name/ Location/Phone Number: _____

Date of Last Chiropractic Visit: _____

Any X -rays: Yes No

MEDICAL HISTORY

Name of Family Doctor: _____

Address/Phone Number: _____

Last full-physical check-up: _____

Are you currently on any medications? YES NO

1) Name: _____ For: _____ Dose: _____ Frequency: _____
2) Name: _____ For: _____ Dose: _____ Frequency: _____

List all the types of surgeries you have had and the year it was performed. YES NO

1) Surgery: _____ Year: _____ Complications: Y N
2) Surgery: _____ Year: _____ Complications: Y N

List any hospitalizations and reason for it:_____

Please **check mark** if you have <u>had or have</u> any of the following problems: YES NO

Vision___
hearing, smell, taste___
dizziness, headaches ___
difficulty swallowing___
loss of balance ___
night sweats___
diabetes___
stroke___
aneurysm ___

heart conditions___
osteoporosis___
arthritis___
prostate disorders____
menstrual problems___
hepatitis ___
HIV infected ___
shortness of breath___
cancer___

STD___
Tuberculosis___
chest pain___
high blood pressure ___
digestive problems___
bowel/bladder problems___
significant weight loss___
pins/needles in arms_____

numbness/weakness in fingers____
numbness/weakness in legs
back pain____
neck pain___
TMJ disorder___
Ear ringing ____
Other_____

For Women: Are you pregnant: Yes, No, Maybe Date of last menstrual period _____

I consent to allow my chiropractor to contact my medical doctor about my health care – Yes No

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FAMILY HISTORY

Only check mark if any of the following family members: mother, father, siblings or grandparents suffer from the below conditions.

Heart Disease ___ Arthritis ___ Cancer ___ Diabetes ___ Psycho/Social Disease ___ Other_____

HEALTH HABITS

Did/do you smoke? Y N Quantity: _____ Did/do you drink alcohol? Y N How Much? _____

How many glasses of water do you drink daily? _____

Do you exercise regularly? Y N

What sports/exercise activities do you enjoy?_____

Sleeping Position: Back Side Stomach Number of Pillows: _____

Did/do you wear orthotics? Y N

TRAUMA HISTORY

PAST CHILDHOOD YES NO

Year: ____ Body Part injured: _____ Did your injury resolve? Y N

Brief account of accident: _____

Did you receive care: Doctor _____ Type of Care given _____

PAST MOTOR VEHICLE ACCIDENT YES NO

Year: _____ Were you: Driver Passenger Wearing Seatbelt: Y N

Collision: Side/ Front/ Rear Did you Strike your head: Y N Loss of Consciousness: Y N

Sent to the hospital: Y N X-Rays Taken: Y N Medications Given: Y N

Did you receive care: Doctor _____ Care Given: _____

Injuries Sustained: _____ Did your injuries resolve: Y N

PAST HOME/SPORTS ACCIDENTS YES NO

Year: ____ Body Part injured: _____ Did your injury resolve? Y N

Brief account of accident: _____

Did you receive care: Doctor _____ Type of Care given _____

PAST WORK ACCIDENTS YES NO

Year: _____ Employer: _____

Claim made with WSIB: Y N Any permanent or partial disabilities:

_____ Body part Injured: _____ X-Rays taken: Y N

Brief account of accident: _____

Did you receive care: Doctor _____ Care Given: _____

Injuries sustained: _____ Did your injuries resolve: Y N

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CURRENT CONDITION

PRESENT COMPLAINT

Sharp__ Dull__ Throbbing__ Aching__ Burning_____ Stabbing_____

Weakness_____ Numbness_____ Tingling_____ Other_____

Location: _____

When did it begin: _____ Have you had this problem before: Y N When: _____

How did this happen? _____

What makes it worse? _____ What makes it better? _____

Does the pain radiate? _____ If yes, where? _____

Is the pain (circle): Constant / Intermittent / Varies / No-Pattern

On a scale from 1 to 10 (10 being the worst pain you've ever experienced), how would you rate your pain?_____

Is it worse (circle): In the morning / Mid-Afternoon / Evening At night (wakes me up)

Please indicate on these figures where you are experiencing your current complaints. Use the legend as a guide