COMMUNITY CHIROPRACTIC HEALTH CENTRE

DR. GRACE TRIDICO DR. BRYAN DUMANSKI
32-B Queen Street East Sault Ste. Marie, Ontario P6A 1Y3
Tel: (705) 942-HEAL (4325) Fax: (705) 942-4324

Date of Initial Visit:

Personal Information

Patient Name:____________________________
Address:_________________________________
City/Postal:______________________________
Best phone number(s) to reach you:
____
____
Email:___________________________________

Sex(circle): M / F Age:_______________
Birthdate(YR-M-D):_______________________

Have you ever seen a chiropractor? Y / N

Name of family doctor or nurse:__________
____
When was your last full physical and bloodwork?____________________________

In case of emergency contact:
Name:___________________________________
Relationship:_____________________________
Phone(s):________________________________

How did you hear about us?_____________

**Please note that all payments are due upon receipt of service. Any costs not covered by benefits are the responsibility of the patient.

Accidents Only

Type of accident:
Auto □ Work □ Home □ Other □
To whom has the accident been reported?
Auto Ins □ Employer □ WSIB □ Other □
Have you sought treatment with any other health professionals: Y / N
Brief description of accident:_____________
____
____
Lawyer info:______________________________
Claim #:__________________________________
Auto Ins. Info:____________________________
____
____
*Please forward any reports to our office as soon as possible.

Extended Coverage Only

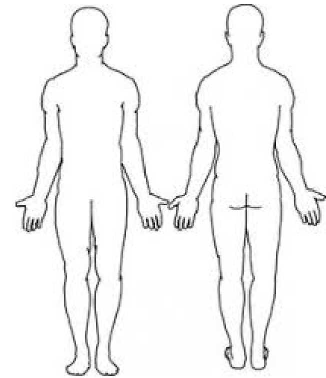
Do you have extended insurance coverage? Y / N
____
Name of Ins. Co.:_________________________
Name of Member:__________________________
Plan#:____________________________________
ID#:______________________________________
you must sign an authorization form & a copy of your benefits card will be kept on file.

Patient Condition

Reason for Visit:____
When did symptoms start:____
I'm feeling: pain□ numbness□ tingling□ Is this condition getting worse? Y / N / unsure.
Rate your pain: mild 1 2 3 4 5 6 7 8 9 10 Unbearable
Feels: sharp□ dull□ throbbing□ shooting□ aching□ stiff□ burning□ other:________________
Is this pain constant, of does it come and go? ____
Continued on next page…
It hurts when I'm: working□ asleep□ daily routine□ recreation□ sitting□ standing□ walking□ bending□ lying down□ Other:____

Has this condition been treated by any other health professional? Y / N
If yes, what treatment did you receive? medication□ surgery□ physical therapy□
Do you have any X-rays or MRIs related to this condition? Y / N
Mark an "X" on the area(s) of your pain/condition:

Describe any other significant details:
____
____
____
____
____
____
____
____



Lifestyle

Medications/Diet	Work/Exercise	Habits
(list all including birth control, allergy, and vitamins /supplements) ________________________ ________________________ ________________________ ________________________ How often do you eat: Fresh greens:_______________ Refined carbs (white pasta, rice etc.): _______________ Wholegrains:_______________ Nightshades:_______________ Fried Foods:_______________ Red meats:_______________ Fish/ Flaxseed:_____________ Fruits:____________________ Cooked Veggies:____________ Sweets:___________________ Fried Foods:_______________	Most of my work is done: sitting□ standing□ repetitive task:__________________ heavy lifting□ variety□ I'm unemployed□ At home I'm mostly: sitting□ active□ cleaning□ I exercise: never□ rarely□ frequently□ My exercise is: walking□ cardio□ weights□ stretching□	I smoke: never□ less than 12 daily□ more than 12 daily□ I drink alcohol: daily□ weekly□ occasionally□ I have caffeine drinks/ chocolate: daily□ weekly□ occasionally□ I feel stressed: rarely□ sometimes□ often□ Rate stress: high□ med□ low□

Are you pregnant? Y / N Due date: _____________ Number of Deliveries: _________________
Please describe any surgeries/hospitalizations or severe injuries you've had and the dates:
____
____
**I certify that all information on these forms is true to the best of my knowledge,

Patient Signature: _________________________ Date: _____________________

Guardian/Parent Signature if under 18yrs: ____________________________

Patient Name:______________________

CONFIDENTIAL HEALTH HISTORY

The items below may relate to your current condition. In the space in front of each item, enter an (X) if you EVER HAD the problem.

GENERAL
1 ____ Fever
2 ____ Chills
3 ____ Night Sweats
4 ____ Loss of Sleep
5 ____ Fatigue
6 ____ Nervousness
7 ____ Weight Loss or Gain
8 ____ Allergies
9 ____ Bleeding Problem
10 ____ Anemia
11 ____ Diabetes
12 ____ Cancer
13 ____ Thyroid Disease/Goiter
14 ____ Alcoholism
15 ____ Drug Abuse

EYE EAR NOSE THROAT
16 ____ Poor Vision
17 ____ Pain in Eye(s)
18 ____ Deafness/Difficulty Hearing
19 ____ Nosebleeds
20 ____ Nose Problems
21 ____ Sinus Trouble
22 ____ Dental Problems
23 ____ Hoarseness
24 ____ Tonsillectomy

GASTROINTESTINAL
25 ____ Poor Appetite
26 ____ Poor Digestion
27 ____ Difficulty Swallowing
28 ____ Belching or Gas
29 ____ Frequent Nausea
30 ____ Vomiting
31 ____ Vomiting Blood
32 ____ Pain over Abdomen
33 ____ Ulcer
34 ____ Black or Bloody Stools
35 ____ Liver Problems
36 ____ Gall Bladder Problems
37 ____ Jaundice
38 ____ Hernia
39 ____ Diarrhea
40 ____ Constipation
41 ____ Hemorrhoids
42 ____ Appendicitis

MEN ONLY
43 ____ Testicular Swelling/Pain
44 ____ Prostate Problems

RESPIRATORY
45 ____ Difficulty Breathing
46 ____ Chronic Cough
47 ____ Spitting Phlegm
48 ____ Spitting Blood
49 ____ Wheezing/Asthma
50 ____ Pneumonia
51 ____ Tuberculosis

CARDIOVASCULAR
52 ____ Irregular Heartbeat
53 ____ High Blood Pressure
54 ____ Pain over Heart
55 ____ Previous Heart Trouble
56 ____ Ankle Swelling
57 ____ Varicose Veins
58 ____ Rheumatic Fever
59 ____ Stroke

GENITOURINARY
60 ____ Frequent Urination
61 ____ Painful Urination
62 ____ Blood in Urine
63 ____ Kidney Diseases
64 ____ Urinary Infection
65 ____ Inability to Control Urination
66 ____ Difficulty Starting Urine Flow
67 ____ Get up ___ times per Night to Urinate
68 ____ Breast Lump or Pain
69 ____ Venereal Infection
70 ____ Sexual Difficulties

SKIN
71 ____ Itching
72 ____ Bruising Easily
73 ____ Change in Mole(s)
74 ____ Skin Cancer

WOMAN ONLY
75 ____ Painful Periods
76 ____ Excessive Flow
77 ____ Irregular Cycles
78 ____ Vaginal Burning/Itching
79 ____ Hot Flashes
80 Date of Last Period Began

____

81 Date of Last PAP Test

____

NEUROLOGIC
82 ____ Weakness
83 ____ Twitching
84 ____ Tremors
85 ____ Headache
86 ____ Fainting
87 ____ Dizziness
88 ____ Convulsions
89 ____ Epilepsy
90 ____ Numbness/Tingling
91 ____ Arm/Leg Pain
92 ____ Mental Disorder

MUSCULOSKELETAL
93 ____ Neck Stiffness/Pain
94 ____ Pain Between Shoulders
95 ____ Low Back Pain
96 ____ Swollen Joints
97 ____ Painful Joints
98 ____ Arthritis
99 ____ Muscle Aches/Soreness
100 ____ Spinal Curvature
101 ____ Fractures

HABITS
102 ____ Smoking
______ packs/day
103 ____ Drinking
104 ____ Recreational Drug Use

EXERCISE
105 ____ None
106 ____ 1-2 times/week
107 ____ 3-5 times/week
108 ____ 6-7 times/week

FAMILY HISTORY
Include information on brothers, sisters, parents and grandparents.
DO NOT INCLUDE YOURSELF

109 ____ Diabetes
110 ____ Thyroid Disease/Goiter
111 ____ Tuberculosis
112 ____ Kidney Diseases
113 ____ High Blood Pressure
114 ____ Heart Disease
115 ____ Cancer
116 ____ Muscle, Bone or Nerve Disease

Community Chiropractic Health Centre

Dr. Bryan Dumanski
CHIROPRACTOR
32-B Queen Street East
Sault Ste. Marie, ON P6A 1Y3

Dr. Grace Tridico, B.Sc., B.S., D.C.
32-B Queen St. E.
Sault Ste. Marie, ON P6A 1Y3
(705) 942-4325

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures and, if necessary, diagnostic X-rays on me by the Doctor of Chiropractic named below (or a designated diagnostic X-ray Centre). I request and consent to the performance of various modes of physical therapy which may be administered by the Doctor of Chiropractic and/or anyone working in this clinic authorized and trained by the Doctor of Chiropractic listed below.

I understand that chiropractic treatment has been demonstrated in government reports and multidisciplinary studies to be highly effective treatment for spinal and joint pain, headaches and other musculoskeletal symptoms. Chiropractic care contributes to your overall well being.

I understand and am informed that, as in all other health care fields, there are very slight possible risks to chiropractic treatment, including but not limited to, muscle spasms and strains, ligament sprains, headache, disc injuries, stroke, rib fractures, and fractures to other areas of the body. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure and treatment which the doctor feels at the time, based upon the facts then known, is in my best interest. I understand that results of treatments are not guaranteed.

I acknowledge having read the above statements and have had the opportunity to discuss and ask questions related to the nature and purpose of chiropractic treatments and chiropractic adjustments, as well as the contents of this consent form, **prior** to examination and treatment.

I consent to the chiropractic treatment offered or recommended to me by the Doctor of Chiropractic, including spinal and/or joint adjustments. I intend this consent to apply to all my present and future chiropractic care.

Date: ______________________

Patient Name: ______________________________________

Patient/Guardian Signature : ___________________________

Doctor Signature: ______________________________
Witness Name (if applicable): ___________________________
Witness Signature (if applicable): ___________________________