Complete Balance Health Centre
2896 Bloor Street West
Toronto, ON, M8X 1B5
(416) 769-1163

Today's Date: _____

First Name				**Last Name**			
Address				**City**		**Postal Code**	
DOB				**Occupation**			
H Telephone		**Cell**		**W Telephone**			
Email							

Physician: _____ Address: _____ Phone: _____
Employer: _____
How did you hear about us? ☐ Friend ☐ Internet ☐Signage Other: _____
Name of Guardian if Applicable: _____
Emergency Contact: _____ Relation: _____ Phone: _____

Do you have a family history of:

Cancer	**YES**	**NO**	Heart disease/stroke	**YES**	**NO**
Diabetes	**YES**	**NO**	Allergies	**YES**	**NO**
			Other(s)_____		

Lifestyle:
Special Interest:_____ Sports:_____
Hobbies:_____ Health Goal: _____
Number of Hours per Week: _____

☐ Coffee	☐No ☐Yes	_____ cups/day
☐ Tea	☐No ☐Yes	_____ cups/day
☐ Cigarettes	☐No ☐Yes	_____ x/day
☐ Alcohol	☐No ☐Yes	_____ x/week
☐ Exercise	☐No ☐Yes	_____ x/week

What type of exercise:_____
_____
Vitamins/ Herbal Supplements? ☐No ☐Yes
What type and dosage:_____
_____

Mental health:
☐ stress
☐ depression
☐ bipolar
☐ others: _____

What level of care are you interested in pursuing?
☐ symptom relief only
☐ preventative and maintenance care

Have you received the following services before?
☐ massage therapy
☐ naturopathy
☐ foot care
☐ psychotherapy
☐ physiotherapy
☐ orthotics

Have you been to a chiropractor before? Yes / No If yes when? _____

Results: (please circle) Excellent Good Fair Poor Dr.'s Name _____

Please indicate by circling any of the following conditions that are causing you a problem.
Please check any conditions that have given you problems in the past.

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness or pain in legs, hands, arms
Allergies
Wheezing
Neuralgia

E.E.N.T
Failing vision
Near sightedness
Far sightedness
Crossed eyes
Eye pain
Deafness
Earache

E.E.N.T Cont'd
Ear discharge
Nose bleeds
Nasal obstruction
Hoarseness
Sore throat
Hay fever
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands

SKIN:
Skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives of allergy

RESPIRATORY:
Chronic cough
Spitting up blood
Spitting up phlegm
Chest pain
Difficulty breathing

CARDIOVASCULAR:
rapid beating heart
slow beating heart
High blood pressure
Low blood pressure
Previous heart stroke
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke

MUSCLE & JOINT:
Stiff neck
Back ache
Neck pain
Swollen joints
Painful tailbone
Foot trouble
Pain in shoulders

M & J Cont'd:
Hernia
Spinal curvature
Faulty posture
Arthritis

GENITOURINARY:
Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Kidney stones
Bed wetting
Inability to control urine
Prostate trouble

GASTROINTESTINAL:
Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Colon trouble

GASTRO Cont'd:
Constipation
Intestinal wounds
Liver trouble
Gall bladder trouble
Jaundice
Colitis
Pain over stomach
Hemorrhoids (Piles)
Bowel Movement:

How often: _____

FOR WOMEN ONLY:
Painful menstruation
Irregular cycle
Cramps or backache
Previous miscarriage
Congested breast
Lumps in breast
Menopausal symptoms
Excessive flow
Hot flashes
# of pregnancies____
# of abortions_____
# of miscarriages____

Currently pregnant? Y / N

HAVE YOUR EVER HAD ANY OF THE FOLLOWING DISEASES? IF SO, PLEASE INDICATE:

Aneurysm	High blood pressure	Hepatitis	Polio	Sleeping difficulty
Cancer	Heart condition	Fatigue	HIV	Psoriasis
Respiratory conditions	Diabetes	Arthritis	Osteoporosis	Pneumonia

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Have you ever been knocked unconscious? Yes / No. If Yes, when and how _____

Have you been treated for your current condition before: Yes/No. If Yes, please explain_____

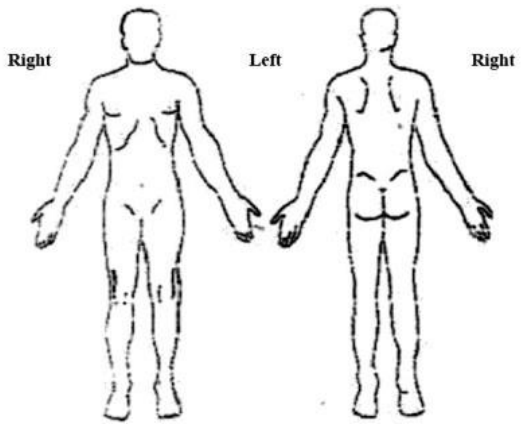
Are you presently taking any medication? Yes / No. If yes please list them: _____

Height: _____ Weight: _____

Pain Diagram

Indicate all areas of

////// Stiffness
●●●● Numbness
0000 Pins & Needles
✕✕✕ Burning
****** Aching**
††† Stabbing



Patient Questionnaire

Accidents / Falls / Fractures / Dislocations (Please describe fully starting with most recent)

_____

_____

Have you had any surgeries? (please list starting with most recent)

_____

SCOLIOSIS QUESTIONS

How old were you when your scoliosis or kyphosis was noticed? _____

Has it gotten BETTER WORSE stayed the SAME (please circle one)

Please describe your EXERCISE HABITS: _____

Family History of Scoliosis: Mother (Y / N); Father (Y / N);

Other relatives (Y / N) Please provide details: _____

Do you have cardiac problems (Y / N)

Do you have visual problems (besides corrective lenses) (Y / N)

Have you seen anyone for your scoliosis treatment? Y / N.

If yes, please describe in details: _____

_____

_____

For FEMALES (Child/Teenager):

Reached onset of MENARCHE: Y / N

if so, having IRREGULAR periods: Y / N

having REGULAR periods: Y / N

PERI / POST MENOPAUSAL Y / N

Age when FIRST PERIOD occurred: _____

For MALES (Child/Teenager): Voice has changed Partially (Y / N) or Fully (Y / N)

NAME: _____ **DATE: _____**

1. Please rate on the pain scale of **0** to **10** with **10** being the worst pain and **zero** being no pain. In the CURRENT RATING column please rate the pain that you are currently experiencing. Under frequency, please √ the box that applies.

Area	Initial Rating	Current Rating	Frequency
Head	/10	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Neck	/10	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Mid-Back	/10	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Shoulder R / L	/10	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Ribs	/10	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Low-Back	/10	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:	/10	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:	/10	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:	/10	/10	**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never

2. Does anything you do **aggravate** your condition(s): ☐ **No** ☐ **Yes** If **yes,** what? _____
3. Does anything **relieve** your discomfort? ☐ **No** ☐ **Yes** If **yes**, what? _____
4. **P**lease identify how your current condition is affecting your ability to carry out these activities.

Activity		No to little Effect			Painful (can do)			Painful (limits)			Unable to Perform	
Bending	N/A	0	1	2	3	4	5	6	7	8	9	10
Concentrating	N/A	0	1	2	3	4	5	6	7	8	9	10
Doing computer work	N/A	0	1	2	3	4	5	6	7	8	9	10
Gardening	N/A	0	1	2	3	4	5	6	7	8	9	10
Playing Sports	N/A	0	1	2	3	4	5	6	7	8	9	10
Recreation Activities	N/A	0	1	2	3	4	5	6	7	8	9	10
Shoveling	N/A	0	1	2	3	4	5	6	7	8	9	10
Sleeping	N/A	0	1	2	3	4	5	6	7	8	9	10
Watching TV	N/A	0	1	2	3	4	5	6	7	8	9	10
Carrying	N/A	0	1	2	3	4	5	6	7	8	9	10
Dancing	N/A	0	1	2	3	4	5	6	7	8	9	10
Dressing	N/A	0	1	2	3	4	5	6	7	8	9	10
Lifting	N/A	0	1	2	3	4	5	6	7	8	9	10
Pushing	N/A	0	1	2	3	4	5	6	7	8	9	10
Rolling Over	N/A	0	1	2	3	4	5	6	7	8	9	10
Sitting	N/A	0	1	2	3	4	5	6	7	8	9	10
Working	N/A	0	1	2	3	4	5	6	7	8	9	10
Climbing	N/A	0	1	2	3	4	5	6	7	8	9	10
Doing Chores	N/A	0	1	2	3	4	5	6	7	8	9	10
Driving	N/A	0	1	2	3	4	5	6	7	8	9	10
Performing Sexual Activity	N/A	0	1	2	3	4	5	6	7	8	9	10
Reading	N/A	0	1	2	3	4	5	6	7	8	9	10
Running	N/A	0	1	2	3	4	5	6	7	8	9	10
Sitting to Standing	N/A	0	1	2	3	4	5	6	7	8	9	10
Walking	N/A	0	1	2	3	4	5	6	7	8	9	10

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and Ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib Fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely Remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal Adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this_____ day of_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ **Name:**_____

(Please print) **(Please print)**