# Patient Introduction

## Dr. Ryan Scott, DC  Dr. Brynne Stainsby, DC

### A Back in the Game Clinic

**Advantage 4 Athletes 500 Denison St. Markham ON, L3R 1B9 (905) 943-4480**

Name ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

_____ _____ _____ Date Today _____ _____ _____

Surname First Name month day year

Address _____ _____ Date of Birth _____ _____ _____

Street Apt. month day year

_____ _____ _____ _____

Town, Village or City Prov Postal Code Age

Phone: Home _____ Business:_____ Consent to leave message : ☐ Yes ☐ No

Occupation:_____

Email Address: _____

How were you referred to our clinic? Please indicate name of reference party:

Friend or Relative ☐ _____

Medical Doctor ☐ _____

Chiropractor ☐ _____

Other ☐ _____

Family Doctor _____ _____ _____

Name Address Phone

Previous Chiropractic Care ☐ Yes ☐ No _____ _____

Name of Clinic or Doctor Date of Last Visit

Emergency Contact _____ _____ _____

Name Relation Phone

Name: _____ File #: _____ Date: _____

What is your major complaint?

How long have you had the symptoms?

Have you ever had previous treatment for your current complaint? ڤ Yes ڤ No, if yes: medical or chiropractic

Have you had any x-rays taken for your current condition? ڤ Yes ڤ No, if yes when?

Have you ever had any type of surgery? ڤ Yes ڤ No, if yes describe

Have you ever had any serious illness? ڤ Yes ڤ No, if yes describe

Do you currently take any medication? ڤ Yes ڤ No, if yes list

Is there any history of serious illness in your family? ڤ Yes ڤ No, if yes describe

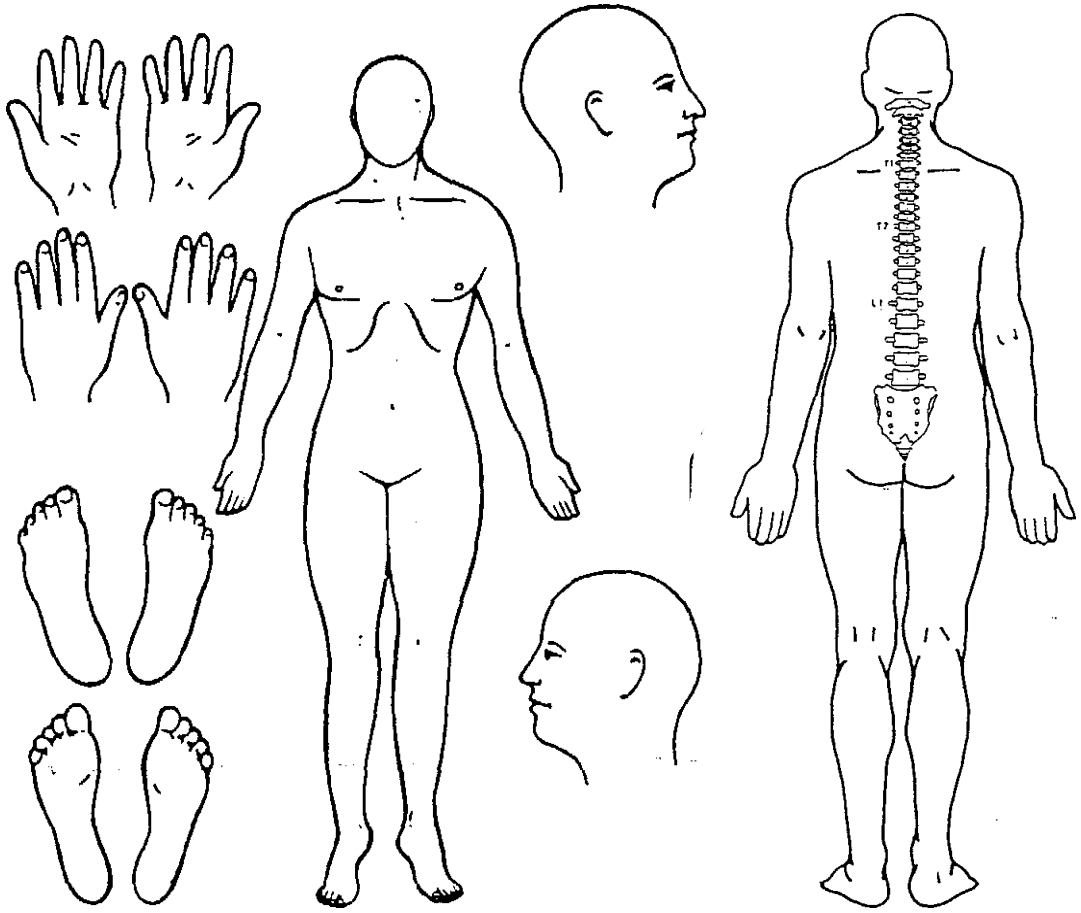
Do you currently take vitamins? ڤ Yes ڤ No, if yes list

Do you have any special medical condition or devices (wires, metal pins, artificial joints, etc.)? ڤ Yes ڤ No, if yes describe

Do you have any other complaints? ڤ Yes ڤ No, if yes describe

Do you have **ANY** medical conditions that we should know about? ڤ Yes ڤ No, if yes describe

**Please fill in diagrams below, including facial expression, to better illustrate the nature of your current complaints:**
**W**-Weakness **R**- Radiating **N**-Numbness **P**-Pain (Sharp) **T**-Tingling **A**-Achy (Dull) **S**-Soreness **ST**-Stiffness



What do you believe is wrong with you? _____

\Name: _____File #: _____ Date: _____

# Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case and will make every effort to refer you to the appropriate health care provider**.** THANK YOU. **IF THIS IS A WSIB CASE PLEASE INFORM RECEPTION AT THIS TIME & DO NOT FILL OUT THIS FORM.**

Please **underline** any of the following symptoms that you now have or place a **check mark (√)** beside any you have had in the past. We want all the facts about your health before we accept your case. **THIS IS A CONFIDENTIAL HEALTH REPORT.**

**GENERAL**

Allergy
Chills
Convulsions
Dizziness
Fainting
Fatigue
Fever
Headache
Loss of sleep
Loss of weight
Nervousness/depression
Neuralgia
Numbness
Sweats
Tremors

**MUSCLE & JOINT**

Arthritis
Bursitis
Foot trouble
Hernia
Low back pain
Lumbago
Neck pain or stiffness
Pain between shoulders
Pain or numbness in:
Shoulders
Arms
Elbows
Hands
Hips
Legs
Knees
Feet
Painful tail bone
Poor posture
Sciatica
Spinal curvature
Swollen joints

**GASTRO-INTESTINAL**

Belching or Gas
Colitis
Colon trouble
Constipation
Diarrhea
Difficult digestion
Distension of abdomen
Excessive hunger
Gall bladder trouble
Hemorrhoids
Intestinal worms
Jaundice
Liver trouble
Nausea
Pain over stomach
Poor appetite
Vomiting
Vomiting of blood

**EYES, EARS, NOSE & THROAT**

Asthma
Colds
Crossed eyes
Deafness
Dental decay
Earache
Ear discharge
Ear noises
Enlarged glands
Enlarged thyroid
Eye pain
Failing vision
Far sightedness
Gum trouble
Hay fever
Hoarseness
Nasal obstruction
Near sightedness
Nosebleeds
Sinus infection
Sore throat
Tonsillitis

**CARDIO-VASCULAR**

Hardening of arteries
High blood pressure
Low blood pressure
Pain over heart
Poor circulation
Rapid heart beat
Slow heart beat
Swelling of ankles

**RESPIRATORY**

Chest pain
Chronic cough
Difficult breathing
Spitting up blood
Spitting up phlegm
Wheezing

**SKIN**

Boils
Bruise easily
Dryness
Hives or allergy
Itching
Skin eruptions (rash)
Varicose veins

**GENITO-URINARY**

Bed-wetting
Blood in urine
Frequent urination
Inability to control kidneys
Kidney infection or stones
Painful urination
Prostate trouble
Pus in urine

**FOR WOMEN ONLY**

Congested breasts
Cramps or backache
Excessive menstrual flow
Hot flashes
Irregular cycle
Menopausal symptoms
Painful menstruation
Vaginal discharge
☐ Yes ☐ No Are you pregnant?
Number of Child Births _____
Any complications? _____

## CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ AIDS/HIV
☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Bleeding disorders
☐ Bronchitis
☐ Cancer
☐ Chorea
☐ Cold sores
☐ Diabetes
☐ Diphtheria
☐ Drug addiction
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Goiter
☐ Gout
☐ Heart disease
☐ Hepatitis
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Miscarriage/D & C
☐ Multiple sclerosis
☐ Mumps
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Stroke
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal Disease
☐ Whooping cough

Name: _____ File #: _____ Date: _____

| HAVE YOU EVER: | YES | NO | DESCRIBE BRIEFLY |
|---|---|---|---|
| Been in a motor vehicle accident? | ☐ | ☐ | _____ |
| Been knocked unconscious? | ☐ | ☐ | _____ |
| Used a cane, crutch or other support? | ☐ | ☐ | _____ |
| Been treated for a spine or nerve disorder? | ☐ | ☐ | _____ |
| Had a fractured bone? | ☐ | ☐ | _____ |
| Been hospitalized other than for surgery? | ☐ | ☐ | _____ |

| DO YOU: | | | |
|---|---|---|---|
| Wear heel lift or arch supports? | ☐ | ☐ | _____ |
| Wear glasses or contact lenses? | ☐ | ☐ | _____ |
| Have an allergy to any drugs? | ☐ | ☐ | _____ |
| Have any other allergies to other substances? | ☐ | ☐ | _____ |

| DATE OF LAST: | Less than 6 months | 6-18 months | Over 18 months | Never |
|---|---|---|---|---|
| Spinal examination | ☐ | ☐ | ☐ | ☐ |
| Physical examination | ☐ | ☐ | ☐ | ☐ |
| Eye examination | ☐ | ☐ | ☐ | ☐ |
| Chest x-ray | ☐ | ☐ | ☐ | ☐ |
| Spinal x-ray | ☐ | ☐ | ☐ | ☐ |
| Dental x-ray | ☐ | ☐ | ☐ | ☐ |

| LIFESTYLE: | Heavy | Moderate | Light | None |
|---|---|---|---|---|
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Coffee | ☐ | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Drugs | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Appetite | ☐ | ☐ | ☐ | ☐ |

PLEASE LIST ANY MEDICAL CONDITIONS THAT YOU HAVE OR HAVE BEEN TREATED FOR PREVIOUSLY

_____

_____

_____

_____

_____

SLEEP:

Sleeping: ☐ Good ☐ Fair ☐ Poor

Sleep postures: ☐ Side ☐ Back ☐ Stomach

Age of mattress _____ ☐ Comfortable ☐Uncomfortable

Age of pillows _____ ☐ Comfortable ☐Uncomfortable