15570 Yonge Street, Unit 5, Aurora, Ontario, L4G 1P2 905-751-1115

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code:\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_
 mm dd yyyy

Would you like to receive our newsletters? Yes □ No □

Single \_\_ Married \_\_ Divorced\_\_ Widowed \_\_ Your Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Chiropractic Care? Yes\_\_\_ No\_\_\_ Dr:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last chiro care :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a child, were you under regular chiropractic care? Yes □ No □

List any supplements/vitamins you are taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many glasses of water do you drink a day?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor’s Name & Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you/how did you hear about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Profile**

**Please check the choice that best describes your current goals for your health and well-being.**

□ I am only concerned about relief of a particular symptom.
□ I am only concerned about relief of a particular symptom and preventing its return.
□ I want optimum health and well-being on every level available to me.
□ Rate your current health from 0 – 100\_\_\_\_\_\_\_. Where would you like that # to be?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the boxes below as they apply to you.**

The chiropractor will ask for further details at the time of your evaluation.
 Yes No Unsure

Did you have any childhood illness? □ □ □
Have you experienced any serious falls? □ □
Are you using any medicine such as antibiotics or an inhaler? □ □

Do/did you smoke? When did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □
What sports/regular activity do you participate in?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □
Do/did you drink alcohol? □ □
Have You been in any accidents? □ □
Have you had any surgery? □ □

 **Current Health Condition**

Reason for consulting our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or wellness care?

When did this condition begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Had this condition before Yes □ No □

If you are experiencing pain, is it … □Sharp or □Dull □Comes and Goes or □Constant

Since the problem started, is it… □About the same or □Getting better or □Getting Worse
What makes your symptom worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do your symptom interfere with: □Work □Sleep □Walking □Sitting □Hobbies □Sports

**Please check all that apply you REGULARLY, even if they do not seem related to your current problem.**

□ Headaches □ Pins and needles in legs □ Fainting □ Dizziness

□ Neck pain □ Pins and Needles in arms □ Loss of smell □ Back pain

□ Loss of balance □ Buzzing in ears □ Ringing in ears □ Nervousness
□ Numbness in fingers □ Numbness in toes □ loss of taste □ Depression

□ Stomach upset □ Fatigue □ Irritability □ Tension

□ Sleeping problems □ Neck stiff □ Cold hands □ Cold feet
□ Diarrhea □ Constipation □ Cold sweats □ Fever
□ Lights bother eyes □ Problems urinating □ Menstrual pain □ Heartburn

□ Menstrual irregularity □ Hot flashes □ Mood swings □ Ulcers

□ stress (work) □ stress (family) □ Difficulty sleeping □ Poor diet

Do you suffer from any other condition (s) other than that which you are now consulting our office?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return To Health Chiropractic accepts payments by Cash, Debit card and Credit Card. I understand that all services are to be paid in full at the time of service, unless alternate arrangements have been made and agreed upon in writing. \_\_\_\_\_\_\_\_\_(initial here please)

The statements on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Signature Date

Doctor Notes:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Chiropractor Signature and Registration number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_