Back To Health Chiropractic Centre - 20 Cranston Park Ave, #6, Maple, ON L6A 2W2 - Dr. Walter Salubro

Name (Last, First)			Birth date (month/day/year)	Today's Date	Patient #
Address		Apt #	City	Province	
Postal Code	Home Phone		Cell Phone	Work Phone	
Business/Employer			Occupation	Sex ❒ Male ❒ Female	
Email Address - PRINT CLEARLY - (for appointment reminders, statements, etc.)					
Marital Status ❒ Married ❒ Single ❒ Widowed ❒ Divorced ❒ Separated ❒ Common-law				# of Children	Children's ages
Name of emergency contact		Relationship to you		Emergency Phone Contact	
Who may we thank for referring you to this office?					
Did you find us on the Internet? If yes, how? · Google · Yahoo · Bing · Our Website · Other What keywords did you search with:					

FOR PRESENT CONDITION MARK AN "X", PAST CONDITIONS MARK "O"

_____ Fractured bones
_____ Auto accidents
_____ 0 – 1 yrs ago
_____ 1 – 5 yrs ago
_____ more than 5
_____ Other accidents / falls
_____ Back curvature
_____ Arthritis
_____ Diabetes
_____ Swollen / painful joints
_____ Convulsion / epilepsy
_____ Skin problems
_____ Cancer
_____ Frequent colds / flu
_____ Depressed
_____ Irritable
_____ Anemia
_____ Tremors
_____ Allergies
_____ Sterility

_____ Sinus problems
_____ Eating disorders
_____ Trouble sleeping
_____ Trouble concentrating
_____ Learning disability
_____ Mood changes
_____ Headaches
_____ Neck pain / stiff R L
_____ Numbness / tingling
R or L __ arms __hands __ fingers
_____ Jaw pain / TMJ R L
_____ Head / shoulders feel tired
_____ Difficulty with ____ standing
____ walking ____bending
____ lifting ____ twisting
_____ Shoulder pain R L
_____ Dizziness
_____ Ringing in ears R L
_____ Hearing loss R L
_____ Fatigue / chronic tiredness

_____ Fainting
_____ Loss of balance
_____ Blurred vision R L
_____ Double vision R L
_____ Upper back pain / stiffness
_____ Mid back pain / stiffness
_____ Low back pain / stiffness
_____ Numbness / tingling
R or L __ buttocks __thighs
___ legs __feet ___toes
_____ Pain with cough or sneeze
_____ Hip pain R L
_____ Chest pain
_____ Asthma
_____ Lung problems
_____ Difficulty breathing
_____ Heart problem
_____ Stroke
_____ High ___low blood pressure
_____ Shortness of breath

_____ Varicose veins
_____ Liver trouble
_____ Gall bladder trouble
_____ Digestive problems
_____ Heartburn
_____ Ulcers
_____ Diarrhea or ___ Constipation
_____ Colon trouble
_____ Hemorrhoids
_____ Prostate problems
_____ Impotence
_____ Kidney trouble
_____ Menstrual problems / PMS
_____ Menopausal problems
_____ Pregnant (now)
_____ Bedwetting
_____ Ear infection
_____ AIDS / HIV
_____ Difficult or painful urination
_____ Stomach problems

List all surgeries: _____

What medications (even non prescription) are you taking? _____

Is your injury due to an accident, injury or trauma? **Yes** _____ **No** _____ If so, was it **AUTO** _____ or **WORK** _____

Describe the events of the accident: _____

Have you seen any other health care providers for this accident, injury or trauma? **Yes** _____ **No** _____ **Who?** _____

What treatment did you receive? _____

Who is your family doctor? **Doctor's Name** _____ **Tel:** _____ **Last Visit Date:** _____

Lifestyle Information:

What's the level of stress in your life? (Circle One) **none minimal mild moderate severe** - Main source of stress? _____

Do you smoke? (check) **No** ___**Yes** ____ **How much per day?** _____

What's your level of exercise? (Circle One) **none sometimes regular** How often per week? _____ **Activity:** _____

What's your sleep position? (Circle One) **on your stomach on your side R or L on your back** Orthopedic Pillow **Yes** ___ **No** ___

How's your diet and nutritional intake? (Circle One) **poor good excellent** Explain: _____Fast food? **Yes** ___ **No** ___

TODAY'S DATE	PATIENT NUMBER

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CONSULTATION / HISTORY REVIEW

Symptoms or conditions which you have listed on the front page may be a result of interference of your nervous system or from Vertebral Subluxations (spinal misalignment)?

Symptoms and pain are the two most common results of **Subluxations (spinal misalignments).** Symptoms and pain are usually signals to let your body know something is wrong.

1. What is your the main health problem or condition that brought you into our clinic today? _____
Is this the first time you have experienced this problem? (check) **Yes** _____ **No** _____
If you checked No, when have you experienced this problem in the past? **When ?** _____

2. Does your pain ever travel into your arms or legs or is it local and stays in one area? (Circle one)
ARM R L LEG R L STAYS IN ONE AREA

3. For how long has this condition been a problem? **How many days?**_____**How many months?**_____**How many years?**_____

4. Describe how your pain feels. Check all that apply to you. ☐**Sharp** ☐**Dull** ☐**Achy** ☐**Burning** ☐**Tingling** ☐**Numbness**

5. A. Please select the number that best represents your ***current pain intensity*** on a 0-to-10 scale where 0 = No pain and 10 = Pain as intense as you can imagine **no pain 0 1 2 3 4 5 6 7 8 9 10 pain as intense as you can imagine**

B. Please select the number that best represents the ***least intensity*** of your pain on a 0-to-10 scale where 0 = No pain and 10 = Pain as intense as you can imagine **no pain 0 1 2 3 4 5 6 7 8 9 10 pain as intense as you can imagine**

C. Please select the number that best represents the ***worst intensity*** of your pain on a 0-to-10 scale where 0 = No pain and 10 = Pain as intense as you can imagine **no pain 0 1 2 3 4 5 6 7 8 9 10 pain as intense as you can imagine**

D. Please select the number that best represents the ***average intensity*** of your pain on a 0-to-10 scale where 0 = No pain and 10 = Pain as intense as you can imagine **no pain 0 1 2 3 4 5 6 7 8 9 10 pain as intense as you can imagine**

6. How many times do you experience this problem during the week: **1x 2x 3x 4x 5x 6x every day**

7. Symptoms may come and go over time. Is your condition **CONSTANT OR INTERMITTENT** (Circle one).

8. Is your condition worse in the: **AM or PM** (Circle one).

9. What have you done to relieve your pain and suffering? _____

10. What is your goal / objective for attending our clinic? _____

11. Please rate your level of commitment to resolving this/these problem(s) (10 being the highest):
1 2 3 4 5 6 7 8 9 10

SOCIAL HISTORY

1. Compare this problem at its worst and when you feel great. How does this problem interfere with:
   a. your ability to work? _____
   b. your ability to enjoy your family? _____
   c. your ability to enjoy your social time? _____
   d. your ability to enjoy your recreational activities, hobbies or sports? _____

FAMILY HEALTH HISTORY

1. Do any members of your family suffer from the same condition? **NO** ____**YES** ____ **Whom:** _____

2. Have your children ever had a spinal check-up? **YES** ____ **NO** ____

3. Is there a history of any of the following conditions in your immediate family (parents, grandparents and siblings)?

Heart disease: YES ____ NO ____ Whom: _____
Stroke: YES ____ NO ____ Whom: _____
Cancer: YES ____ NO ____ Whom: _____
Diabetes: YES ____ NO ____ Whom: _____

Thank you for your input. This information will be very beneficial in helping the doctor to understand your health history, while being very specific and respectful of your time. We look forward to helping you discover the root cause of your problem or condition.