



PATIENT INFORMATION

S. Dales S. DeWolfe E. Douglas

PERSONAL INFORMATION (please fill this out as completely as possible) **DATE:** _____

First Name: _____ Initial: _____ Last Name: _____

Address: _____ Suite #: _____

City: _____ Province: _____

Country: _____ Postal Code: _____

Date Of Birth (d/m/y): _____ Age: _____ Sex: _____

Occupation: _____ Referred by: _____

Home #: _____ Work #: _____

Fax #: _____ Cell #: _____

E-mail Address: _____

Name of Family Physician: _____ Phone #: _____

Address: _____

Name of Previous Chiropractor: (if any) _____

Address: _____ Phone #: _____

When was your last visit? (d/m/y) _____ Comments: _____

Hospitalization: When? _____ For What Condition? _____

Surgeries: (type & date) _____

Accidents/Falls: (minor/major, type & date) _____

Chief Complaint: _____

Purpose of consulting this office, please check one:

- I am interested only in help with my current condition(s), i.e. relief
- I am interested in help with my current condition(s) and in learning how to correct and prevent it in the future, i.e. corrective care.
- I have no current problem, but I am interested in achieving the optimum level of functioning possible through preventive care, i.e. comprehensive care.

30 Wellington Street West, Toronto Ontario M5L 1A1 T: 416.214.0100 F: 416.214.0113
info@commercecourthealth.com www.commercecourthealth.com

Check here if you do not want to receive any correspondence from our office



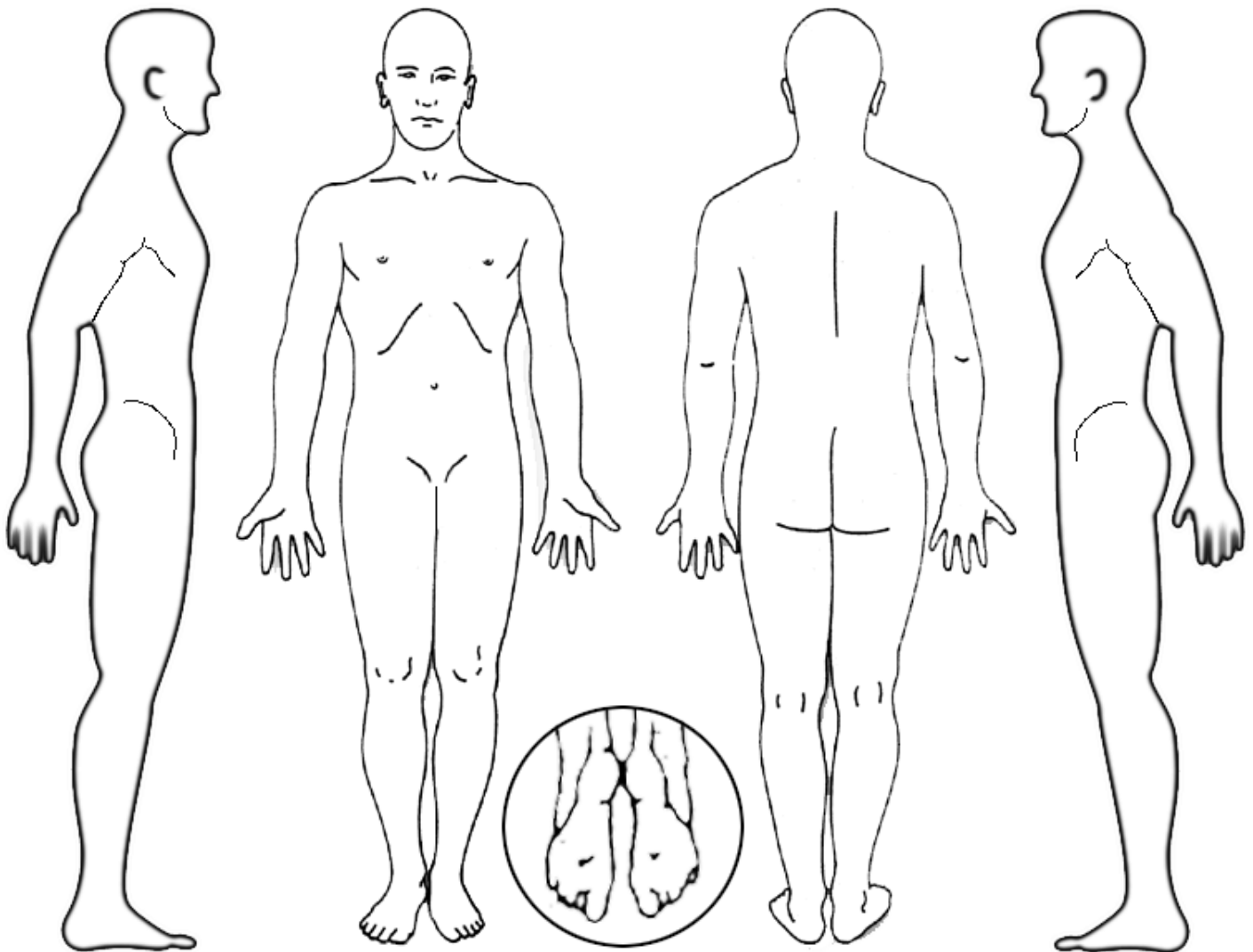
PATIENT INFORMATION

S. Dales S. DeWolfe E. Douglas

PATIENT NAME: _____ **DATE:** _____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES SHOWN BELOW.

Pain = XXXX Stiffness = //// Numbness = 00000 Other (Specify): _____





HEALTH HISTORY

S. Dales S. DeWolfe E. Douglas

PATIENT NAME: _____ **DATE:** _____

Below are a list of conditions the may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care. Please enter a check mark in front of all the signs and symptoms which you may have experienced presently or occasionally. A complete history and understanding of you health status will facilitate care.

MUSCULO-SKELETAL SYSTEM

- LOW BACK PROBLEMS
- PAIN BETWEEN SHOULDERS
- NECK PROBLEMS
- ARM PROBLEMS
- LEG PROBLEMS
- SWOLLEN JOINTS
- PAINFUL JOINTS
- STIFF JOINTS
- SORE MUSCLES
- WEAK MUSCLES
- WALKING PROBLEMS
- BROKEN BONES

GASTRO-INTESTINAL SYSTEM

- POOR APPETITE
- EXCESSIVE HUNGER
- DIFFICULT CHEWING
- DIFFICULT SWALLOWING
- EXCESSIVE THIRST
- NAUSEA
- VOMITING FOOD
- VOMITNG BLOOD
- ABDOMINAL PAIN
- DIARRHEA
- CONSTIPATION
- BLACK STOOL
- BLOODY STOOL
- HEMORRHOIDS
- LIVER TROUBLE
- GALL BLADDER PROBLEMS
- WEIGHT TROUBLE

CARDIO-VASCULAR-RESPIRATORY

- CHEST PAIN
- PAIN OVER HEART
- DIFFICULT BREATHING
- PERSISTENT COUGH
- COUGHING PROBLEMS
- COUGHING BLOOD
- RAPID HEARTBEAT
- BLOOD PRESSURE PROBLEMS
- HEART PROBLEMS
- LUNG PROBLEMS
- VARICOSE VEINS

NERVOUS SYSTEM

- NUMBNESS
- LOSS OF BALANCE
- LOSS OF FEELING
- PARALYSIS
- DIZZINESS
- FAINTING
- HEADACHES
- MUSCLE JERKING
- CONVULSIONS
- CONFUSION
- DEPRESSION

GENITO-URINARY SYSTEM

- BLADDER TROUBLE
- EXCESSIVE URINE
- SCANTY URINATION
- PAINFUL URINATION
- DISCOLOURED URINE
- PREGNANT (DUE: _____)

EYE, EAR, NOSE & THROAT

- EYE STRAIN
- EYE INFLAMMATION
- VISION PROBLEMS
- EAR PAIN
- EAR NOISES
- EAR DISCHARGE
- HEARING LOSS
- NOSE PAIN
- NOSE BLEEDING
- DIFFICULT BREATHING THROUGH NOSE
- NOSE DISCHARGE
- SORE GUMS
- HOARSENESS
- DIFFICULT SPEECH
- JAW PAIN

FEMALE

- VAGINAL DISCHARGE
- VAGINAL BLEEDING
- VAGINAL PAIN
- BREAST PAIN
- LUMPS ON BREAST
- PERIOD IRREGULARITY

OTHER

- BLOOD CLOT DIFFICULTIES
- EASILY BRUISED
- CANCER
- THYROID
- DIABETES



HEALTH HISTORY

S. Dales S. DeWolfe E. Douglas

PATIENT NAME: _____ **DATE:** _____

HABITS

Smoking _____ pks/day Supplements: _____
 Alcohol _____ oz/day _____
 Coffee _____ cups/day Medicines: _____

EXERCISE

None Moderate (2-3 times/week) Daily: ____# of hours/day _____# of hours/week

FAMILY HISTORY

Mother Diabetes Heart Kidney Cancer Back Pain Neck Pain Arthritis
Father Diabetes Heart Kidney Cancer Back Pain Neck Pain Arthritis