Wellness First Physiotherapy and Chiropractic

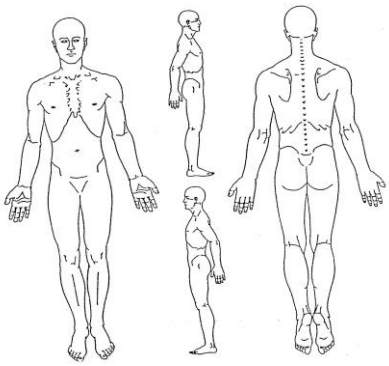
7315 Woodbine Ave., Markham, Ontario L3R 3V7 (905) 477-6578

□ Dr. Lorne Papernick BSc., B.Ed., D.C. □ Dr. Michael Whitley BSc., B.Ed., D.C.
□ Dr. William Webber BSc., D.C. □ Dr. Sajad Abolghasem BSc. Hon., D.C.

Confidential Intake Forms

Name:			Date:
Address:		City:	Postal Code:
Home Phone:	Work Phone:	Date of Birth (DD/MM/YY):	Age:
Cell Phone:	Email address:		Sex: □ Male □ Female □ Other
Occupation / Retired:		Employer:	
Family Doctor's Name: Phone: May we communicate with your family doctor concerning your health? □ Yes □ No			
Do you have children? □ Yes □ No	How did you hear about our office?		

What is your **main** complaint? _____



When did it start bothering you? _____

How frequent/often does it bother you? □ Daily □ Weekly □ Monthly

Has the pain gotten? □ Better □ Stayed the same □ worse

Circle where pain is located on diagram to the left.

On a scale of 0-10 how would you rate the pain?
(Circle) 0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

Is the pain?
□ Constant
□ Comes and goes

How would you describe the pain? □ Dull/achy □ Sharp/stabbing □ Burning □ Numbness/tingling
□ Stiff/tight □ Other_____

Does the pain travel (radiates) anywhere? □Yes □ No If yes, where? _____

What aggravates and/or make the pain worse? _____

What actions have you taken, if any, to eliminate or reduce this health concern? □ Chiropractic □ Massage
□ Physiotherapy □ Medication □ MD □Other_____

Is the pain due to? □ Trauma □ Work (WSIB) □ Accident (MVA) Date of incident: _____

Have you had any recent imaging? □ X-rays □ MRI □ CT □ Ultrasound

When you **cough or sneeze** does it **aggravate** the pain? □Yes □ No

Is there any **pain that wakes you up** from a dead sleep? □Yes □ No

Have you experienced **unexplained severe weight loss** or **gain lately**? □Yes □ No

Patient Name: _____ Date: _____ File #_____

Are you having any other issues? □ Blurred vision □ Balance issues □Fainting □Buzzing in ears
□Dizziness □Difficulty speaking □ Recent infections (fever, rash, etc)

Has anyone in your **family** ever experienced any of the following? □ Osteoporosis □ Diabetes □ Stroke
□ Heart attack □ Cancer □ High blood pressure □ High cholesterol □ Other_____

Have **you** ever experienced any of the following? □ Osteoporosis □ Diabetes □ Stroke □ Heart attack
□ Cancer □ High blood pressure □ High cholesterol □ Other_____

Do **you** suffer from any of the following? □ Bowel trouble □ Bladder trouble □ Fractures
□ Chronic illness □ Childhood illness □ Arthritis □ Blood disease □ Digestive issues □ Heart issues
□ Respiratory issues □ Thyroid issues □ Sprains/strains □ Other _____

Please list the following, if applicable:
Surgeries: _____
Medications: _____
Allergies: _____
Past accidents: _____

Lifestyle:
Cigarettes? □Yes □ No If yes, # cigarettes/week: _____
Alcohol? □Yes □ No If yes, # drinks/week: _____
Water: # glasses / day: ____ Exercise: _____ times / wk
Sleeping Posture: □ Side □ Stomach □ Back Sleep per night: ____ hrs.

What are your goals for treatment?
□ Pain relief □ Prevention □ Core strength □ Improve posture □ Stress reduction

Female only: Are you pregnant? □ Yes □ No
Do you have any menstrual issues? □ Yes □ No

A comprehensive examination includes both history and physical components are required to make a complete working diagnosis and a plan of management. I understand, request, and consent to these chiropractic procedures including history and physical examinations, and diagnostic imaging (if necessary). I acknowledge and understand the information I have provided is true and complete to the best of my knowledge and that it is my responsibility to keep my health care provider updated about any changes to my health.

_____ _____ _____
Patient /Legal Guardian Signature Witness Signature Date

Do you have insurance? □ Yes □ No Company name: _____

Is Chiropractic Covered? □ Yes □ No

Is Massage Covered? □ Yes □ No