

Welcome to Balanced Health Care!

You will be meeting our chiropractor, Dr. Katherine Tibor, who will be looking at your spine and nervous system to determine the cause of your condition. Please fill out the information below as this will help Dr. Katherine during the initial visit.

YOUR FIRST VISIT – The Initial Visit:

Dr. Katherine will conduct a thorough health history and physical exam. The physical exam will include checking your posture, spinal mobility, nerve function, and muscle strength. After this, Dr. Tibor may recommend that you get a set of x-rays taken. This will give her a clearer picture of your spinal health and help her provide you with the best care possible.

DURING YOUR SECOND VISIT: - The Report of Findings:

Dr. Katherine will go over the results from the first visit with you. She will provide a diagnosis, present a treatment plan that is best suited for your needs, and initiate your care that day.

Name: _____ Today's date: _____

Address (incl. apt#): _____ Postal code: _____

Date of birth (DD/MM/YY) _____ Age: _____ Sex: _____ Pronouns: _____

Home Telephone: (____) _____ Work/cell phone: (____) _____

Can we leave a message here: Y N Can we leave a message here: Y N

Email: _____ Occupation: _____

Emergency contact (Relation) : _____ Phone:(____) _____

Who referred you to us? _____

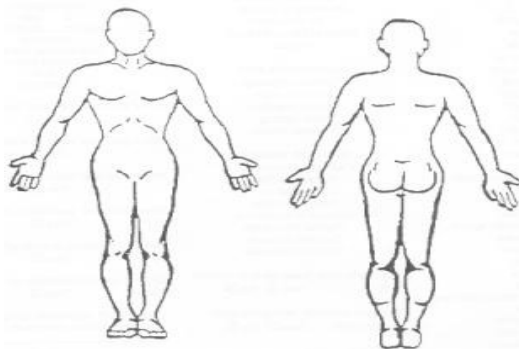
Family doctor: _____ Family doctor's #: _____

May we contact him/her: Y N

#1 Current Health Concern(s):

Please mark the area(s) on your body that are causing you **pain** or **unusual sensation(s)** with the appropriate symbols.

- Numbness or tingling o o o
- Pins and needles : : :
- Burning x x x
- Dull or aching / / /
- Stabbing + + +
- Stiff or tight 2 2 2



Rate your pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain ever)

How often does it occur? _____ What relieves it? _____

Any associated concerns? _____ What aggravates it? _____

What is the pain keeping you from doing? _____

Which other professionals seen for this concern? _____ Any X-rays / CT / MRIs? Yes No

Is this a WSIB case? Yes No Is this a motor vehicle accident? Yes No

Date of accident: _____ Date of accident: _____

#2 Physical Stresses:

List all significant *injuries, traumas and motor vehicle accidents* during childhood and adulthood:

List all hospital visits for *surgeries, possible fractures, concussions, trauma, childbirth(s)* or other reasons including dates:

Are you in *prolonged postures* during the day (*repetitive work / lifting / sitting / driving etc.*)?

Yes No Unsure If yes, please explain: _____

What is your usual *exercise routine*? _____

#3 Chemical Stresses:

List any current prescriptions or over-the-counter medications:

List any supplements (*vitamins / minerals / herbs etc.*):

Do you smoke? Yes No _____/day How long have/did you smoke? _____ years

How would you rate your diet? Excellent Good Poor

#4 Mental/Emotional Stresses:

Rate your stress level: 0 (no stress) 1 2 3 4 5 6 7 8 9 10 (severe stress)

You sleep on your: Back Side Stomach Hours of sleep per night: _____

#5 Nervous System and General Health:

Do you have a *significant history* or *recent experiences* with any the following?

- | | | | |
|-----------------------|-----------------------|------------------------|--------------------------|
| Allergies | Depression | Infertility | Rashes/hives |
| Anxiety | Diabetes | Irregular menstruation | Recurrent ear infections |
| Arthritis | Dizziness | Loss of balance | Sleep problems |
| Asthma | Eczema | Loss of consciousness | Stroke |
| Bladder problems | Fatigue | Loss of smell/taste | Swallowing difficulty |
| Bruise easily | Headaches | Loss of weight | Ulcers |
| Breathing difficulty | Hearing problems | Multiple Sclerosis | Vision problems |
| Cancer | Heart disease | Nausea/vomiting | Weakness |
| Chest pain | High blood pressure | Night sweats | |
| Constipation/diarrhea | Indigestion/heartburn | Painful menstruation | Other : _____ |

Family history of: Arthritis Cancer Diabetes Heart Disease Osteoporosis

#6 Chiropractic Goals:

People seek chiropractic care for several reasons and have certain goals and expectations. Please check which statement best applies to you:

- I have a specific problem and I require help only with this problem.
- After my specific problem has been relieved, I am interested in strategies to help ensure it does not return.
- After my specific problem has been resolved and I have followed advice to help ensure it does not return, I am interested in strategies to improve my general health.
- I have no symptoms and I feel well. I am interested in strategies to help me feel and function even better.

I give the doctor my consent to a complete health history, physical examination, and x-rays, if required.

Patient/Guardian's signature: _____ Date: _____