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. Katherine 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 and present a treatment plan that is best suited for your needs. She will then start chiropractic care to get your *spine in line*!

Name:_____ Today's date:_____

Address:_____Postal code:_____

Date of birth (DD/MM/YY) _____ Age: _____ Gender: F M

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:(___)_____

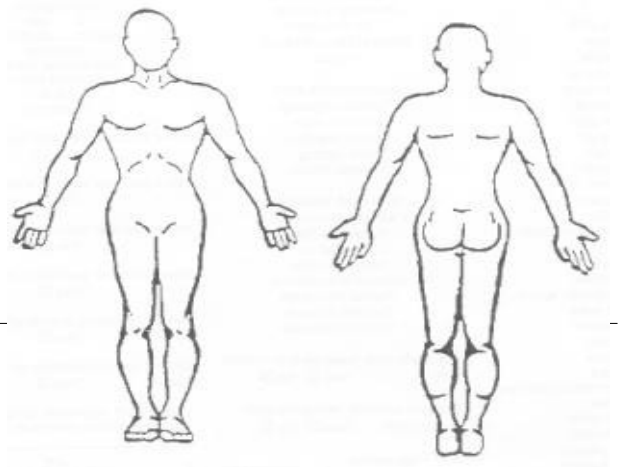
Who referred you to us? _____

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

If this there is pain, please rate it: 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
Date of accident: _____

Is this a motor vehicle accident? Yes No
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, child birth(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:

Psychological stress has been shown to negatively affect the function of the nervous system. Rate your overall mental / emotional stress level:

0 (no stress) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

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

#5 Nervous System and General Health:

Current or past illnesses/conditions can cause interfere with the function of the nervous system. Do you have a s*ignificant 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 a number of reasons and have certain expectations and perceptions. 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 Dr. Tibor my consent to a complete health history, physical examination, and x-rays, if required. Unless discussed with Dr. Tibor, payments will be made in full after each chiropractic appointment in accordance with the current fee schedule. I allow for occasional health newsletters from Balanced Health Care to be emailed to me. These newsletters may include health information, educational/promotional events, and/or any updates pertaining to the clinic. I understand that I am able to unsubscribe from these emails at anytime.

Patient/Guardian's signature: _____ Date:_____