DISCOVER CHIROPRACTIC - Dr. Cheryl Pacheco

162 Huron St., Stratford, ON N5A 5S8

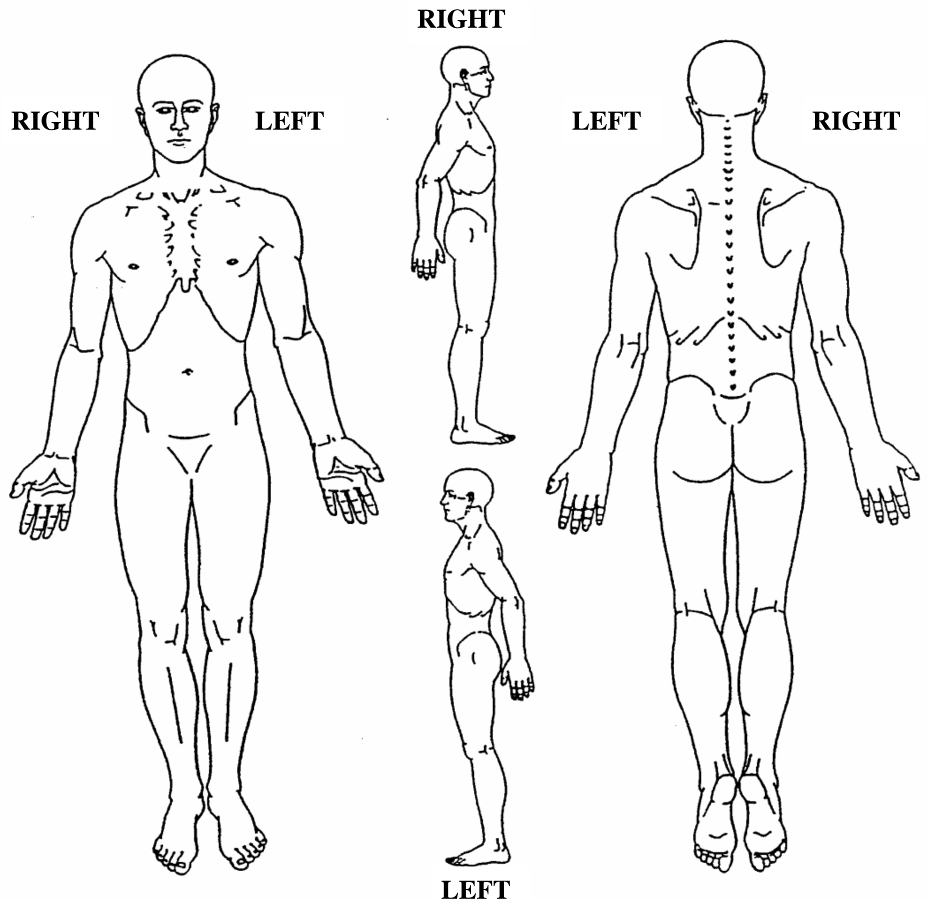
Name	**Home #**
Address	**Cell #**
	Postal Code
Date of Birth (DD/MM/YYYY) :	**Email Address**
❑**Male** ❑**Female**	**Work #**
Employer:	**Occupation:**
Job Description:	**Work Schedule:**
REFERRED BY:	**Family Doctor:**

Have you ever received Chiropractic care before: ❑ NO ❑ YES

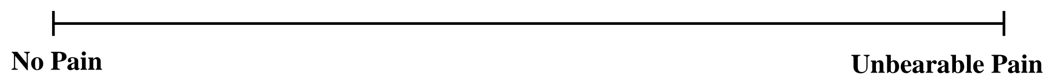
IF YES, WHEN / WHO? ____

Use symbols below to mark the diagram at the right to indicate the *type* and *location* of your symptoms.	
Numbness	?????????????
Burning	////////////////////
Dull & Aching	+ + + + + + +
Weakness	wwwwwwww
Pins & Needles	……………...
Stabbing / Sharp	xxxxxxxxxxx
Stiff & Tight	22222222222

PLEASE INDICATE THE CONDITIONS YOU ARE CONCERNED ABOUT:
O HEADACHE PAIN
O NECK PAIN
O UPPER/MID BACK PAIN
O LOW BACK PAIN
O SHOULDER-ELBOW PAIN
O WRIST-HAND PAIN
O HIP-KNEE PAIN
O ANKLE-FOOT PAIN
O OTHER



Please mark an "X" on the line that corresponds to the intensity of your pain.



No Pain **Unbearable Pain**

What is your primary complaint? ____

____

Have you ever had this condition before: ❑ NO ❑ YES - WHEN? ______________________________

Symptoms / complaints: ❑ COME & GO ❑ ARE CONSTANT

Symptoms are worse in: ❑ MORNING ❑ AFTERNOON ❑ NIGHT

Duration of symptoms: _____HOURS _____DAY(S) _____WEEK(S) _____ MONTH(S) _____YEARS(S)

If you were to guess, what do you think is causing your condition?

____

____

Have you missed any work as a result of your condition? Yes No If Yes, how much? ______________

Please check the following activities that aggravate your condition:

❑ BENDING ❑ REACHING ❑ WALKING ❑ COUGHING ❑ SITTING DOWN ❑ DRIVING
❑ LIFTING ❑ SNEEZING ❑ STRAINING AT STOOL ❑ LYING DOWN ❑ STANDING

Please check the following that help relieve your condition:

❑ REACHING ❑ BENDING ❑ SITTING DOWN ❑ STANDING ❑ HEAT ❑ EXERCISE
❑ LIFTING ❑ WALKING ❑ LYING DOWN ❑ MASSAGE ❑ ICE ❑ REST

Has this condition interfered with any of the following:

❑ SLEEP ❑ ENERGY LEVEL ❑ RECREATION ❑ JOB
❑ APPETITE ❑ IMMUNE SYSTEM ❑ SOCIAL LIFE ❑ OTHER: ______________________________

Have you noticed any changes in your functional habits:

❑ URINATION ❑ APPETITE ❑ BOWEL MOVEMENTS ❑ MENSTRUAL CYCLE

Please list any current medications including vitamins, minerals and supplements: ______________

____

____

Please list any allergies: ____

Do you smoke? ❑ NO ❑ YES - HOW MUCH? ______________________________
Do you drink alcohol? ❑ NO ❑ YES - HOW MUCH? ______________________________

List pregnancies and / or menstrual difficulties:

____

____

Surgery and Hospitalizations (list with dates):

____

____

____

Falls and Accidents (list with dates):

____

____

Have you ever been knocked unconscious? If Yes, please describe: ______________________________

____

____

Personal Medical History

Have you experienced or are you experiencing any of the following? Check any that apply.

- ❑ Ringing in the ear
- ❑ Ear infections
- ❑ Dizziness/fainting
- ❑ Failing vision
- ❑ Eye Infections
- ❑ Nose Bleeds
- ❑ Sinus Trouble
- ❑ Hay Fever/Allergies
- ❑ Bronchitis
- ❑ Chronic Cough
- ❑ Asthma
- ❑ Chest pain
- ❑ High Blood Pressure
- ❑ Heart Murmur
- ❑ Leg pain – walking
- ❑ Varicose veins
- ❑ Loss of appetite
- ❑ Difficulty Swallowing
- ❑ Indigestion
- ❑ Heartburn
- ❑ Persistent Nausea
- ❑ Shoulder Problems
- ❑ Difficult/ Restless Sleep
- ❑ Change in bowel habits
- ❑ Diarrhea
- ❑ Constipation
- ❑ Diverticulitis
- ❑ Bloody Stools
- ❑ Hemorrhoids
- ❑ Bladder Infections
- ❑ Blood in Urine
- ❑ Kidney Stones
- ❑ Venereal Disease
- ❑ Chronic Fatigue
- ❑ Weight Loss – Recent
- ❑ Weight Gain – Recent
- ❑ Anemia
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Convulsions/ Seizures
- ❑ Black – outs
- ❑ Gall Bladder Trouble
- ❑ Jaundice/Hepatitis
- ❑ Muscle Weakness
- ❑ Numbness/ Tingling Sensations
- ❑ Headaches
- ❑ Arthritis/ Rheumatism
- ❑ Osteoporosis
- ❑ Back Pain – Recurrent
- ❑ Bone Fracture/ Joint Injury
- ❑ Gout
- ❑ Foot Pain
- ❑ Rashes/Hives
- ❑ Psoriasis/Eczema
- ❑ Nervousness/ Depression
- ❑ Memory Loss
- ❑ Mental Illness
- ❑ Prostate Disease
- ❑ Menstrual Problems
- ❑ Sexual Dysfunction
- ❑ Swollen Ankles

Family Medical History

Check below if your parents or other blood relatives have had any of the following conditions

- ❑ Arthritis
- ❑ Cataracts
- ❑ Diabetes
- ❑ Strokes
- ❑ Colitis
- ❑ Alzheimer's
- ❑ Cancer
- ❑ Glaucoma
- ❑ Psoriasis
- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Multiple Sclerosis
- ❑ Lou Gehrig's disease
- ❑ Neurologic disorder
- ❑ Peptic Ulcer disease
- ❑ Blood disorders
- ❑ Osteoporosis
- ❑ Thyroid Disorders

OFFICE POLICIES

1. Remove coat and shoes before entering adjustment room
2. In adjustment room, please remove belt and all items from pockets before lying on table.
3. Inform the doctor of any new symptoms, fall or accidents that have occurred since last visit.
4. 24 hour notice is requested for appointment cancellation or rescheduling to avoid missed appointment fee.
5. A $15 fee will be charged and collected for missed appointments (no call / no show)
6. Fees to paid on *each* visit. We accept cash, debit, Visa and MasterCard.
7. Personal cheques are no longer accepted unless special arrangement has been made. NSF charge is $25.

I have read and fully understand the office policies listed here. By signing below, I agree to them.

______________________ ______________________ ______________

Signature **Print Name** **Date**