Welcome to Zavitz Family Chiropractic

Please take a few moments to answer the following questions to help Dr. Zavitz and Dr. Meredith better understand your health care needs.

Name: _____ Date:_____ Gender: □ Male □ Female □ Other

Birth Date: ____/____/_____ (DD/MM/YYYY) Cell Ph: _____ Home Ph: _____

Email: _____ Would you like to receive our e-newsletter? □ Yes □ No

Address: _____ City: _____ Postal Code: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse's Name: _____

Names and Ages of Children: _____

Emergency Contact Name: _____ Number: _____ Relationship: _____

Who can we thank for referring you to our clinic? _____

Medical Doctor: _____ Date of last visit: _____ Date of last physical: _____

Claim will be made against:

1. Recent Motor Vehicle Accident? □ Yes □ No If yes, are you filing through MVA? □ Yes □ No
2. Work-related injury/accident? □ Yes □ No If yes, are you filing through WSIB? □ Yes □ No

Your Health History

Why Is this Information Important?

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health. Most of the times the effects are gradual: not even felt until they are serious. Please, answer every question.

The Beginning Years (to age 17)

Research is showing that most of the health changes that occur later in life have their origins during the developmental years, some starting at birth. Please, answer every question to the best of your ability.

Did you have a childhood illness? Yes/ No
Did you have any serious falls as a child? Yes/ No
Did you play youth sports? Yes/ No
Did you take/ use prescription medication Yes/ No
Did you have any surgeries? Yes/ No
Have you fallen from a height of over three feet? (i.e. bunkbed, tree, crib) Yes/No
Were you involved in any car accidents as a child? Yes/ No

Did you suffer any other Traumas? (physical or emotional) Yes/ No
Was there any prolonged use of medication Such as antibiotics or an inhaler? Yes/No
As a child, were you under regular chiropractic care? Yes/No
Were you delivered : Naturally/ C-section/ forceps/ vacuum/ induced

Adult Years (age 18 to present)

Do/Did you smoke? Yes/ No
Do/Did you drink alcohol? Yes/ No
If Yes: # drinks per week? 1-3 4-7 7-9 10+
Have you been in any accidents? Yes/ No
If so was your nervous system checked by a chiropractor afterwards? Yes/ No
Have you had any surgeries? Yes/ No
For what? _____

Do/did you participate in extreme sports? Yes/ No
Do/did you play contact sports? Yes/ No
On a scale from 1-10 rate your stress level (1– none, 10-severe)

Occupational stress_____ Personal stress_____

Does your job require:
Heavy lifting: Yes/ No Repetitive stresses: Yes/ No
Prolonged sitting: Yes/ No

Name: Date:

Present Health Concern(s)

What is currently your primary health concern? _____

If you have no specific symptoms or complaints, and are here mainly for wellness services, please check (x) here ____ and skip to ***"Prior Chiropractic Care".*** *Those who have a health complaint need to describe the chief area of complaint in the section below.*

What do you think caused this condition? _____

How long have you had this condition? _____

What makes it worse? _____

What makes it better? _____

Have you had a similar condition in the past? Yes/ No if yes, explain:_____

Are you getting pain or numbness in your arms or legs? Yes/ No if yes, explain:_____

Pain Severity *(0 = No pain)* 0 1 2 3 4 5 6 7 8 9 10 (*10 = worst pain ever)*

My condition is: Getting worse Getting better Staying the same Constant Comes and goes

If you are experiencing pain, it is: Sharp Dull Burning Tight Throbbing

Other practitioners who have treated this condition? (eg. *chiropractor, medical doctor, massage, physiotherapist):*_____

How is this condition interfering with your life? (*circle)*

Work Daily routine Hobbies/Sports Relationships Family life Emotion Sleep

Please rate your level of commitment to resolving this/these problem(s) (10 being the highest)

1 2 3 4 5 6 7 8 9 10

Are you currently taking any medications? (please list):

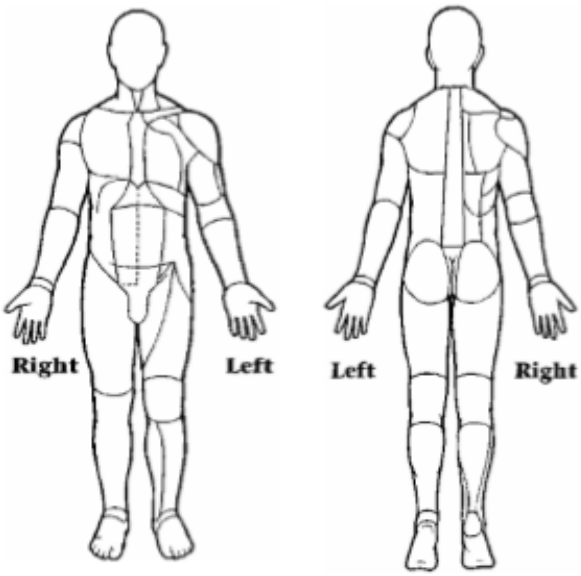
_____

Check off all present pain/problems and circle where appropriate

□ Shoulder: Pain / Numbness / Tingling Left/ Right
□ Arm: Pain / Numbness / Tingling Left / Right
□ Hand: Pain / Numbness / Tingling Left / Right
□ Hip: Pain / Numbness / Tingling Left / Right
□ Knee: Pain / Numbness / Tingling Left / Right
□ Foot: Pain / Numbness / Tingling Left / Right
□ Leg: Pain / Numbness / Tingling Left / Right

□ Neck: Pain / Tightness □ Facial Pain
□ Headaches □ Migraines □ Upper Back Pain
□ Middle Back Pain □ Low Back Pain □ Sacroiliac Pain
□ Rib Pain □ Other: _____

Please indicate with an X on the diagram where pain is present



Prior Chiropractic Care

Have you had chiropractic care before? Yes/ No
Name of chiropractor/clinic: _____ City: _____
When was your last adjustment?_____ How often were you adjusted? Weekly Monthly Other:_____
Were Xrays taken? Yes/ No Date:_____ Significant findings:_____
How long were you under care?_____ Why did you stop?_____
How were your results? Excellent Good Fair Poor

Name: Date:

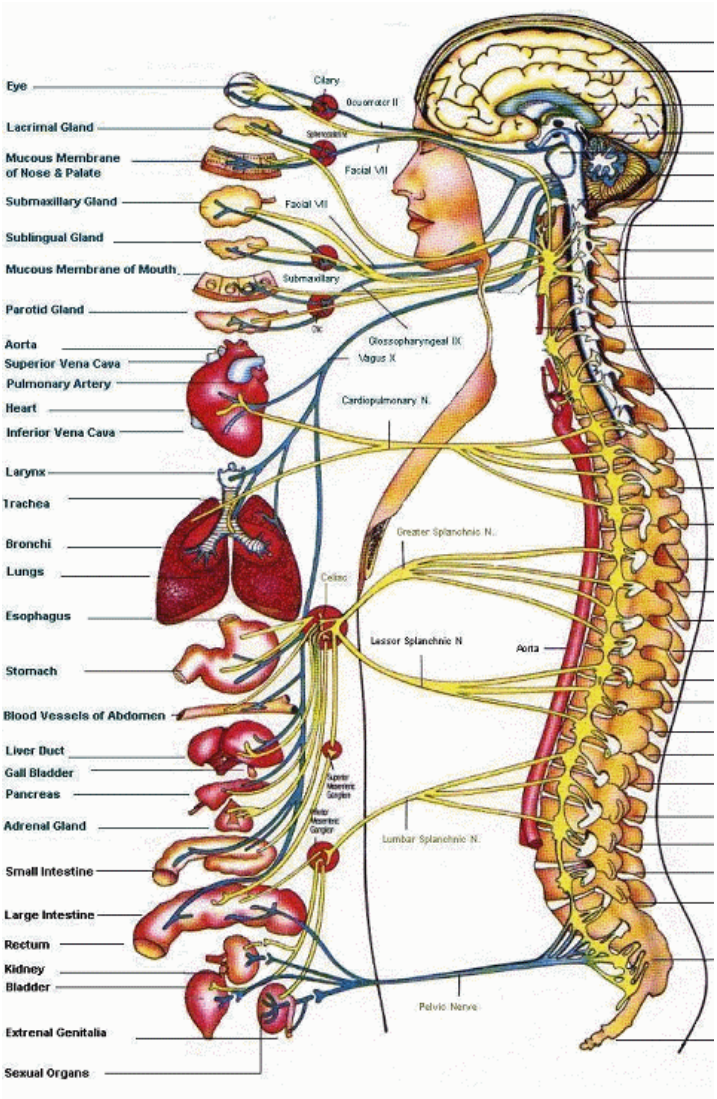
Systems Review of your Organ Health

Please check off ALL of the following you have EVER had even if you don't think they are related to the current problem:

Cardiovascular System
□ Chest pain
□ Shortness of breath
□ Heart condition/ disease
□ High/low blood pressure
□ High cholesterol
□ Swelling of legs

Respiratory System
□ Asthma
□ Seasonal allergies
□ Frequent colds
□ Pneumonia
□ Chronic cough
□ Difficulty breathing
□ Tuberculosis

Digestive System
□ Heartburn
□ Indigestion
□ Stomach cramps
□ Constipation
□ Diarrhea
□ Food allergy
□ IBS
□ Crohn's Disease
□ Ulcers/colitis
□ Belching/gas
□ Bloating
□ Nausea/vomiting
□ Liver/gallbladder trouble
□ Colon trouble
□ Black/bloody stool
□ Bladder incontinence
□ Kidney stones



Head and Neck
□ Blurred/failing vision
□ Deafness/ringing in ears
□ Recurrent ear infections
□ Sinus infections
□ Sore throat/tonsillitis
□ Thyroid problems
□ Adrenal problems

Reproductive System
For males:
□ Prostate dysfunction
For females:
□ Painful menstruation/cramping
□ Excessive/irregular flow
□ Ovarian cysts/PCOS
□ Endometriosis
□ Fertility problems

Other Symptoms
□ Fainting/dizziness
□ Seizures/convulsions
□ Loss of balance/vertigo
□ Tremors
□ Skin problems (psoriasis)
□ Anemia
□ Poor memory/concentration
□ Insomnia/loss of sleep
□ Learning disability
□ Emotional instability/depression
□ Anxiety
□ Chronic fatigue

□ Stroke
□ Aneurysm
□ Osteoporosis (low bone density)
□ Multiple sclerosis
□ HIV
□ Hepatitis
□ Diabetes
□ Autoimmune disease: _____
□ Cancer: _____
□ History of Substance Abuse

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