TAUNTON CHIROPRACTIC
AND HEALTH CENTRE

File#_____

Name:_____Date:_____

Sex: Male ☐ Female ☐ Date of Birth(DD/MM/YY):_____

Address:_____ City:_____ Postal Code:_____

Phone #: (Home) _____ (Work) _____

(Cell)_____ (Other) _____

Email Address: _____

Emergency Contact Name and Phone Number: _____

_____

Family Doctor Name and Address: _____

_____

_____

I hereby authorize Taunton Chiropractic and Health Centre, with my prior knowledge, to release to or obtain any health information from my other healthcare providers as may be required for the management of my case.

I have read and understand the Taunton Chiropractic and Health Centre fee schedule and cancellation policy. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy.

Client Signature: _____

TAUNTON CHIROPRACTIC
AND HEALTH CENTRE

File#_____

Date of Last Appointment or physical: _____

Occupation: _____

What do you do mostly? (sit/stand/etc.)_____

Height:_____ Weight: _____

How did you hear about our clinic? _____

Please describe your present complaint: _____

_____

When did it occur? _____ _____

How did it occur? _____

_____

Have you received any treatment for this condition, and if so what kind of treatment?

_____

Has any treatment helped? _____

Have you ever had a similar problem to your current complaint? _____

Were X-rays taken? YES ☐ NO ☐

Have you been to a chiropractor before? Y / N When was your last treatment? _____

Was this an injury that occurred at work? Y / N Was it reported? Y / N

Was this an injury as a result of a car accident? Y / N Is there a claim pending? Y / N

Do you currently smoke? Y / N

How often do you exercise and what type of activity is it? _____

_____times/week

Any Prior Surgery? _____

_____

Prior Hospitalizations? _____

Have you broken any bones? _____

TAUNTON CHIROPRACTIC
AND HEALTH CENTRE

File#_____

Do you currently take any prescription or over the counter medications or vitamins/nutritional supplements? Y / N

Specify: _____

_____

_____

_____

What would you like to achieve by coming to our clinic? _____

_____

_____

(Our primary goal is always to work toward the resolution of your condition as quickly as possible!)

Do you have any concerns about the therapy that you would like us to address before we begin treatment?

_____

_____

_____

(We believe that good client communication is essential and we always want to know your perspectives – positive or negative.)

Females Only:

Date of last menstrual period? _____ Are you currently pregnant? Y / N

Have you ever taken birth control pills? _____

Are you currently taking birth control pills? _____

How many children do you have? _____

How many pregnancies? _____

TAUNTON CHIROPRACTIC
AND HEALTH CENTRE

File#_____

Family Health History

Have your grandparents, parents or siblings ever been diagnosed with any of the following?

- ☐High blood pressure
- ☐Heart disease
- ☐Stroke
- ☐Diabetes (Type I or TypeII)
- ☐Thyroid / Hormone problems
- ☐Breathing or lung problems
- ☐Rheumatoid Arthritis
- ☐Osteoarthritis
- ☐Neurological problems
- ☐Cancer
- ☐Kidney Disease
- ☐Other specify:

Client Health History

Please **check anything which is causing you problems right now**
Please **circle anything which as been a problem in the past**

- ☐Persistent fatigue
- ☐Headache
- ☐Fever
- ☐Sweats
- ☐Fainting
- ☐Dizziness
- ☐Loss of Sleep
- ☐Numbness
- ☐Tingling
- ☐Weight Loss
- ☐Pain

- ☐Back Ache
- ☐Swollen Joints
- Foot Pain L / R
- Shoulder Pain L / R
- Elbow Pain L / R
- Wrist Pain L / R
- Hand Pain L / R
- Hip Pain L / R
- Knee Pain L / R
- ☐Arthritis
- ☐Weakness
- ☐Loss of Strength
- TMJ Problems L / R

- ☐Breast Lump/Pain
- ☐Severe Menstrual Cramps
- ☐Hot Flashes
- ☐Irregular Cycle

- ☐Chronic Cough
- ☐Spitting up Blood
- ☐Chest Pain
- ☐Difficulty Breathing

- ☐Blurred Vision
- ☐Double Vision
- ☐Deafness
- ☐Earache
- ☐Asthma
- ☐Frequent Colds
- ☐Sinus Problems
- ☐Enlarged Glands
- ☐Speech Problems
- ☐Difficulty Swallowing
- ☐Seizures/Epilepsy
- ☐Bleeding Disorder
- ☐High Blood Pressure
- ☐Stroke
- ☐Varicose Veins
- ☐Hardening of Arteries
- ☐Swelling of Ankles
- ☐Heart or Blood Disease
- ☐Heat/Cold Intolerance
- ☐High Cholesterol

- ☐Rashes
- ☐Itching
- ☐Bruise Easily
- ☐Skin Dryness
- ☐Boils
- ☐Hives (allergy)

- ☐Ulcer
- ☐Diabetes
- ☐Poor Appetite
- ☐Indigestion
- ☐Excessive Hunger
- ☐Belching or Gas
- ☐Nausea
- ☐Vomiting
- ☐Pain Over Stomach
- ☐Constipation
- ☐Diarrhea
- ☐Hemorrhoids
- ☐Jaundice
- ☐Gallbladder Problem
- ☐Bed Wetting
- ☐Frequent Urination
- ☐Difficulty Urinating
- ☐Blood in Urine
- ☐Kidney Infection

TAUNTON CHIROPRACTIC
AND HEALTH CENTRE

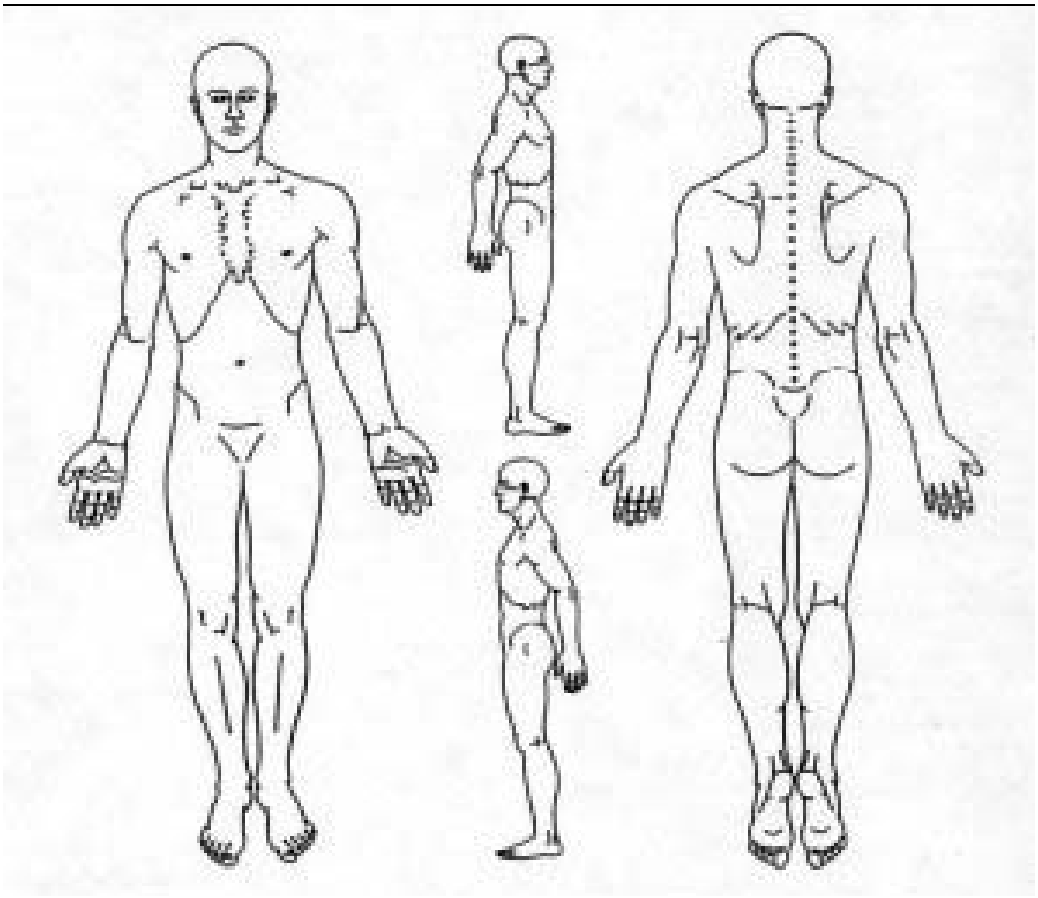
File#_____

Name: _____ Date: _____

INDICATE THE SEVERITY OF YOUR SYMPTOMS

0 5 10
No Symptoms Extreme Symptoms

PLEASE CIRCLE YOUR AREA OF COMPLAINT AND INDICATE THE TYPE OF SYMPTOM AND IT'S SEVERITY.



ACHE X X X X X X STIFFNESS * * * * * *

STABBING 2 2 2 2 2 2 NUMBNESS + + + + + +

PINS & NEEDLES 0 0 0 0 0 0

DR. MICHAEL FERET/DR. TYLER MOORE - 1383 WILSON RD. N. OSHAWA, ONTARIO L1K 2Z5