Unique Family Chiropractic

4-201 Williamson Dr. W. Ajax, Ontario L1T 0J8

Dr. Jillka Kapadia
Dr. Robbie Berman
Family Wellness Chiropractors
416-342-1932
www.uniquechiropractic.com

CONFIDENTIAL PATIENT INFORMATION

WHY THIS FORM IS IMPORTANT

At Unique Family Chiropractic, we focus on your entire family's ability to be healthy. Our goal is to understand the reasons which brought you to our Clinic and to assist you and your family by offering the opportunity to improve your health through a wellness lifestyle including chiropractic care.

Stress is accumulative; it may cause you to lose your ability to adapt to your environment and is a major cause of poor health. Most stresses on the body are subtle and effects are gradual. By answering the following questions you will give us a profile of the types of stresses you have faced in your lifetime. This knowledge allows us to better understand your challenges and helps identify what may be limiting your ability to adapt and express your true health potential.

GENERAL INFORMATION:

Name: ______________________________ Date: ______________

Address: ______________________________ Home Phone: ______________

City, Province, Postal Code: ______________________________ Work Phone: ______________

Email Address: ______________________________ Cell Phone: ______________

Date of Birth: (D)______ (M)______ (Y)_________ Age: _____ Gender: Male ☐ Female ☐ OK to leave a voicemail: Yes / No

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law ☐ Number of Children: ______________

Occupation: ______________________________ Family Physician: ______________

How did you hear about us? Internet ☐ Facebook ☐ Doctor ☐ Friend / Family ☐ Live Nearby ☐ Coach ☐ Other: ______________

Who may we thank for referring you? ______________________________

Have you seen a Chiropractor in the past? Yes ☐ No ☐ If yes, who and when? ______________________________

HEALTH HISTORY:

What brought you to our clinic? **Preventative/Wellness Care** ☐ **Health Concern** ☐

If you have a health concern please describe: ______________________________

Your nervous system is involved with every system of your body, and can affect its function. **Please check the areas where you have any health issues:**

Neck Pain		Mid Back		Low Back		Stroke	
Headaches / Migraines		Shortness of Breath		Digestive Issues		Heart Disease	
Poor Vision / Hearing		Asthma / Allergies		Constipation / Diarrhea		Diabetes	
Dizziness / Fainting		Heart Condition		Muscle Issues		Cancer	
Depression		Weakness in the Body		Joint Issues		High Blood Pressure	
Anger		Low Energy		Bone Issues		Other:	

Women Only: Menstrual Cramps ☐ Excessive Menstruation ☐ Irregular Cycle ☐ Hot Flashes ☐ Pregnant ☐

Prescribed Medications (ie. Blood Pressure Pills): Yes ☐ No ☐ Please list: ______________________________

Over-the-counter Medications (ie. Aspirin): Yes ☐ No ☐ Please list: ______________________________

Vitamins/Supplements/Natural Products (ie. Multi-vitamin): Yes ☐ No ☐ Please list: ______________________________

Have you had x-rays, CT's or MRI's taken in the last six months? Yes ☐ No ☐ If yes, where? ______________________________

Have you had surgeries? Yes ☐ No ☐ If yes, please list: ______________________________

Family History:

Health problems tend to run in families so please list the family member and any health condition(s) or concerns:

Relation:	Name:	Age:	Health Condition(s) or Concerns:

Unique Family Chiropractic
4-201 Williamson Dr. W. Ajax, Ontario L1T 0J8

Dr. Jillka Kapadia
Dr. Robbie Berman
Family Wellness Chiropractors
416-342-1932
www.uniquechiropractic.com

LIFETIME STRESS PROFILE:

Did you: as a:	Child	Teenager	Adult	None
Play contact sports	☐	☐	☐	☐
Have any serious falls or traumas	☐	☐	☐	☐
Get involved in any car accidents	☐	☐	☐	☐
Use medication for extended periods	☐	☐	☐	☐
Have any work injuries		☐	☐	☐
Used street drugs for extended periods		☐	☐	☐
Drink alcohol		☐	☐	☐
Smoke cigarettes		☐	☐	☐

On a scale from 1 – 10 describe your **stress level** (1 – None / 10 – extreme)

Personal: _________

Occupational: __________

LIFESTYLE QUESTIONAIRE:

How would you rate your overall health	Poor	Good	Excellent
How would you rate your career satisfaction	Low	Medium	High
How would you rate your overall stress level	Low	Medium	High
How would you rate your overall happiness level	Low	Medium	High
How would you rate your commitment to improve your health	Low	Medium	High
How often do you take a vacation	Never	Sometimes	Often
How often do you take time to relax	Never	Sometimes	Often
How would you rate the likelihood that you'll skip a meal	Low	Medium	High
How would you rate your daily water intake	Poor	Good	Excellent
How would you rate your level of exercise	Low	Medium	High
How would you rate your quality and quantity of sleep	Poor	Good	Excellent
How would you rate your support from family and friends	Poor	Good	Excellent

We invite you to discuss with us any questions regarding our care. The best health services are based on a friendly, mutual understanding between you and the doctor.

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for services rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: ____ Date: ____________________

Signature: ____ Dr.'s Initials: ________________