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: _____ Parent's Work Phone: _____

Email Address: _____ Cell Phone: _____

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

Name of Parents: _____ Family Physician: _____

Child's Height: _____ Child's Weight: _____

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

Who may we thank for referring you? _____

Has your child seen a Chiropractor in the past? Yes □ No □ If yes, who and when? _____

HEALTH HISTORY:

What brought your child to our clinic? **Preventative/Wellness Care** □ **Health Concern** □

If they have a health concern please describe: _____

Your child's nervous system is involved with every system of their 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		Colic		Digestive Issues		Heart Disease	
Ear Infections		Asthma / Allergies		Constipation / Diarrhea		Diabetes	
Dizziness / Fainting		Heart Condition		Muscle / Joint / Bone Issues		Cancer	
Depression / Anger		Postural Issues		Bedwetting		Scoliosis	
Attention Deficit Disorder		Low Energy		Menstrual Issues		Other:	

Prescribed Medications (ie. Antibiotics): Yes □ No □ Please list: _____

Over-the-counter Medications (ie. Tylenol, Advil): Yes □ No □ Please list:

_____

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

Has your child had x-rays, CT's or MRI's taken in the last six months? Yes □ No □ If yes, where? _____

Has your child 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

Does / Did your Child:	Yes	No
Play contact sports	☐	☐
Had any serious falls or traumas	☐	☐
Been involved in any car accidents	☐	☐
Use antibiotics for extended periods	☐	☐
Wear a heavy backpack	☐	☐
Had a traumatic birth (ie: forceps, vacuum, c-section)	☐	☐
Had nightmares	☐	☐
Has behavioural issues	☐	☐

LIFESTYLE QUESTIONAIRE:

How would you rate your child's overall health	Poor	Good	Excellent
How would you rate your child's overall stress level	Low	Medium	High
How would you rate your child's overall happiness level	Low	Medium	High
How would you rate the likelihood that your child skip a meal	Low	Medium	High
How would you rate your child's daily water intake	Poor	Good	Excellent
How would you rate your child's level of exercise	Low	Medium	High
How would you rate your child's quality and quantity of sleep	Poor	Good	Excellent
How would you rate your child's 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 for my child. I understand that any fee for services rendered is due at the time of service and cannot be deferred to a later date.

Print Child's Name: _____ Date: _____

Print Guardian/Parent Name: _____ Dr.'s Initials: _____

Guardian/Parent Signature: _____