CHAMPION CHIROPRACTIC
& WELLNESS CENTRE

Please tell us about yourself:

Name: _____ DOB: _____

Address: _____

Cell Phone #: _____ Leave a message Yes ▢ No ▢

E-Mail: _____ Occupation: _____

Would you like an email reminder for future appointments? Yes ▢ No ▢

Emergency Contact: _____ Telephone: _____

Relationship: _____

Is this a Workplace Safety and Insurance Board (WSIB) Injury: Yes ▢ No ▢
Are your injuries related to a Motor Vehicle Accident: Yes ▢ No ▢

How did you hear about us:

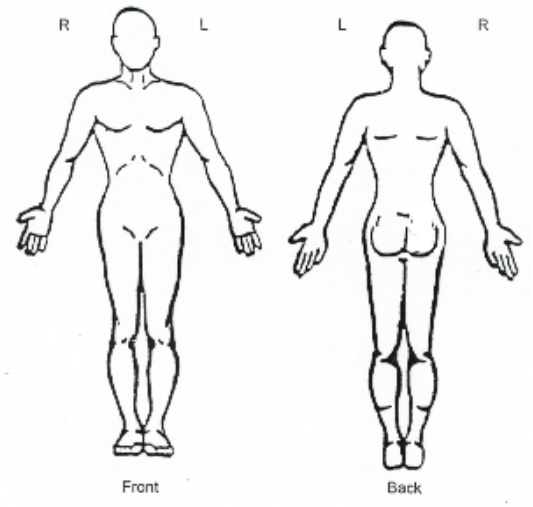
Internet ▢ Facebook ▢ Signage ▢

Other: _____

Is there someone we can thank for referring you? _____

What is your primary complaint? _____
_____

Please draw your pain on the diagram:



Numbness: = = =

Sharp & Stabbing: s s s

Dull & Aching: o o o

Burning: x x x

Stiff & Tight: 2 2 2

Please rate your pain:

0 1 2 3 4 5 6 7 8 9 10

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Personal Medical History

Please mark an '**X**' for any conditions or symptoms you are experiencing ***currently***
Please mark a '√' for any conditions or symptoms you have experienced in the ***past***

❑ Allergies	❑ Diabetes	❑ Loss of Strength
❑ Angina	❑ Difficulty Breathing	❑ Low bone density
❑ Arthritis	❑ Digestion issues	❑ Nausea
❑ Blackouts	❑ Dizziness	❑ Night Sweats
❑ Bleeding Disorder	❑ Epilepsy	❑ Numbness/tingling
❑ Blood in Urine	❑ Excessive thirst	❑ Osteoporosis
❑ Blurred/Double Vision	❑ Fainting	❑ Problem Speaking
❑ Bowel/Bladder Disorders	❑ Fever	❑ Problem Swallowing
❑ Cancer	❑ Headaches	❑ Rashes/Itching
❑ Chest Pain	❑ Hearing problems	❑ Ringing in the ears
❑ Chronic Cough	❑ Heart Attack	❑ Spitting up blood
❑ Circulatory Problems	❑ High Blood Pressure	❑ Stroke/TIA
❑ Clumsiness	❑ High Cholesterol	❑ Swelling of joints
❑ Concussions	❑ Kidney Issues	❑ Tremors
❑ Depression or Anxiety	❑ Loss of Sleep	❑ Varicose Veins
		❑ Weight loss/gain

Please list any:

Medications you are currently taking: _____
Fractures and injuries & When: _____
Imaging (x-ray, MRI, CT, etc):_____
Surgeries/hospitalizations & when:_____
Car accidents & when:_____
Are you currently a smoker? □ Yes □ No □ Previously

WOMEN: Are you currently pregnant? □ Yes □ No
Are you on birth control pill/patch? □ Yes □ No □ Previously How Long?: _____

Have you had chiropractic treatment in the past? Yes ▢ No ▢
If yes, when? _____
Have you had physiotherapy treatment in the past? Yes ▢ No ▢
If yes, when? _____
Have you had registered massage therapy treatment in the past? Yes ▢ No ▢
If yes, when? _____

Family Medical History

Do you have a family history of:

Cancer ▢ Diabetes ▢ Heart Disease ▢ Stroke ▢
Hypertension ▢ High Cholesterol ▢ Other: _____