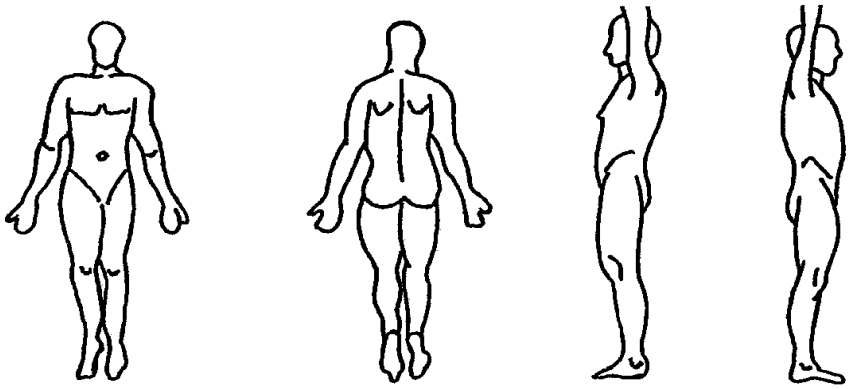
downtown **core**
chiropractic & acupuncture centre

New Patient Admission Form

Name:_____ Date:_____
Date of birth: (d/m/y) ___/___/___ Occupation:_____
Address (home): _____
City: _____ Province: _____ Postal code:_____
Phone: home: _____ office: _____ cell: _____
email address:_____ Number of Children: _____
Name of Medical Doctor: _____ Phone: _____
Address: _____ Date of last visit: _____
Who referred you to us? _____

Please answer the following questions:

1. What are the main reasons you wish to see the Chiropractor? _____
2. How long have you had this problem? _____ Have you had it before? _____
3. What aggravates the problem? _____ Relieves it? _____
4. What do you expect from treatment? _____
5. Please use the following drawings to mark the areas where you are having an issue:



Mark on this scale the level of your pain today (T) and in general (G):

(0 = no pain) 0------1------2------3------4------5------6------7------8------9------10 (10 – worst pain)

6. Mark the treatments that you have received so far for this problem:
   medication ☐ chiropractic ☐ acupuncture ☐ physiotherapy ☐ massage ☐
   other (please specify) _____

7. So far, which treatment(s) have benefited you the most? _____

Dr Doris Mertins ☐ Dr Darcie Sinclair ☐ Dr Roberta Da Re ☐

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416-368-4858 info@downtowncore.ca

Patient Name: _____

8. List all the medications and supplements you are taking, or have recently taken:
   _____
9. Have you ever had any accidents, falls, surgery, trauma, or injuries?
   _____
10. Do you have any scars? (please list) _____
11. Please list quantity/day: caffeine _____ cigarettes _____ alcohol _____
12. Have you or has anyone in your family had: Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Diabetes ☐ Cancer ☐ HIV/AIDS ☐ Other _____
    Specify whom: _____

Please check the appropriate symptom below if you have experienced it in the past (✓) or circle if you are experiencing it now.

MUSCULOSKELETAL SYSTEM

Neck Pain ☐	Jaw Problems ☐	Upper Back Pain ☐
Shoulder Problems ☐	Elbow Problems ☐	Wrist/Hand Problems ☐
Low Back Pain ☐	Hip/Groin Pain ☐	Weak/Sore Knees ☐
Ankle Problems ☐	Foot Problems ☐	Heel Pain ☐

Other muscle/joint problems (specify):_____

HEAD AND NECK

Headaches ☐	Hearing Problems ☐	Ringing of the Ears ☐
Migraines ☐	Dizziness ☐	Eye Problems ☐
Nasal Problems ☐	Sinus Problems ☐	Hoarse Voice ☐
Vision Problems ☐	Sore Throat ☐	

Other problems in these areas (specify): _____

CHEST, LUNGS, HEART, AND SKIN

Chest Pain ☐	Palpitations ☐	Rapid Heart Beat ☐
Chest Tightness ☐	Blood Pressure Issues ☐	Excessive Dreaming ☐
Insomnia ☐	Night Sweats ☐	Excessive Sweating ☐
Little Sweating ☐	Lung Problems ☐	Asthma ☐
Shortness of Breath ☐	Allergies ☐	Skin Problems ☐
Restlessness ☐	Nail Fungus ☐	Anxiety ☐
Bruising easily ☐	Heavy Legs ☐	Varicosities ☐

Other problems in these areas (specify): _____

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DIGESTIVE SYSTEM

Bleeding Gums ☐	Nausea/Vomiting ☐	Belching ☐
Heart Burn ☐	Poor Appetite ☐	Excessive Appetite ☐
Loss of Taste ☐	Bloating ☐	Abdominal Pain ☐
Gas, Rumbling ☐	Sleepy after meal ☐	Diarrhea
Constipation ☐	Hemorrhoids ☐	Gain/Lose weight easily ☐

Other digestive problems (specify): _____

GYNECOLOGICAL SYSTEM

Painful Periods ☐	Heavy Periods ☐	Irregular Periods ☐
Long Periods ☐	Absent Periods ☐	Pre-Menstrual Symptoms ☐
Hot Flashes ☐	Endometriosis ☐	Painful Intercourse ☐
Fertility Issues ☐	Breast Issues ☐	Miscarriages ☐

Number of Children: _____

Other gynecological issues (specify): _____

LIVER AND GALL BLADDER

Liver Problems ☐	Gall Bladder Problems ☐	Sweats Easily ☐
Irritated Easily ☐	Brittle Nails ☐	Bitter Taste in Mouth ☐
Muscle Cramps ☐	Sweaty Palms ☐	Tension Headaches ☐
Slow Digestion ☐	Stiff Joints and/or Muscles ☐	

KIDNEY, URINARY TRACT AND ENDOCRINE SYSTEM

Kidney Stones ☐	Kidney Problems ☐	Bladder Problems ☐
Prostate Problems ☐	Frequent Urination ☐	Urinary Tract Infection(s) ☐
Incontinence ☐	Low Sexual Drive	Erectile Dysfunction ☐
Feeling Cold ☐	Feeling Hot ☐	Low Energy ☐
Cold Hands ☐	Cold Feet ☐	Bone Problems ☐

Other Kidney, Urinary Tract or Hormonal Issues (please specify): _____

Please list ANY other health concerns: _____

PLEASE DO NOT WRITE BELOW THIS LINE

Patient Accepted: Yes ☐ No ☐ Referred to: _____

Doctor's Signature: _____

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