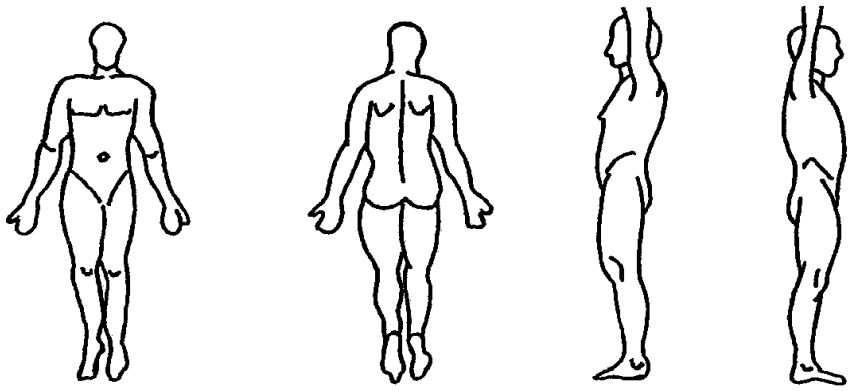
downtown **core**
chiropractic & acupuncture centre

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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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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What to Expect on your First Visit at Downtown Core Chiropractic & Acupuncture Centre

You may be coming to see the chiropractor for a check-up, a specific injury, or something more complex. In order to assess your health status and formulate a diagnosis the chiropractor will take a detailed history, and will examine you as well. If you are not already wearing loose fitting clothing, you may be asked to change into a gown or shorts for the examination.

The examination may include, but may not be limited to: a postural check, orthopaedic tests, neurological tests, muscle and joint testing. Occasionally, some of these tests may provoke pain during or after the examination.

I understand that these tests are a necessary part of my care and consent to examination by the chiropractor.

Date _____ **Patient initials** _____ **Chiropractor initials** _____

Further testing, if not already performed, may be recommended such as blood tests, or imaging (x-rays, ultrasound, etc).

After completing the assessment, the chiropractor will discuss her findings and diagnosis with you as well as treatment options. You are always encouraged to ask questions so that you have a good understanding of what is happening with your body.

If you wish to proceed with care, and the chiropractor does not need to gather any further information, you will receive your first treatment at the end of the initial visit.

Your initial visit, including treatment may take 45-60 minutes. Please allow enough time for your full visit when you schedule your appointment.

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