The Centre for
Health & Rehabilitation

1160 Clarence Street Unit 5 & 6
Woodbridge, ON, L4H 2V3
905-652-4811 905-652-4812

Vibrant Square, 2640 Rutherford Road, Ste E201
Vaughan, ON, L4K 0H3
905-553-4814 905-553-4815

www.chrehab.ca

Patient Information

First Name _____ Last Name _____ Date _____

Address _____ Apt _____ City _____ Prov _____ Postal Code _____

Home Phone _____ Cell Phone _____ Email _____

Date Of Birth _____ Occupation _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Other: _____ Gender ☐ M ☐ F

Emergency Contact: Name _____ Telephone _____ Relationship _____

Family Doctor: Name _____ Telephone _____

How Did You Hear About Us? ☐ Friend ☐ Sign ☐ Advertisement ☐ Other:

Health Information

Please list your medical conditions:	Medications:	Allergies:
		Alcohol: ☐ Yes ☐ No Amnt/wk: _____
		Smoking: ☐ Yes ☐ No Amnt/d: Yrs: _____
		Regular exercise: ☐ Yes ☐ No Hrs/wk: _____
		Hours of sleep/night: _____
		Are you pregnant? ☐ Yes ☐ No Due date:

Previous surgeries and year:

Accidents/Injuries/Fractures:

Type: _____ Year: _____ Area Of Injury: _____

Type: _____ Year: _____ Area Of Injury: _____

Type: _____ Year: _____ Area Of Injury: _____

Please check if you have any of the following

☐ Loss Of Consciousness ☐ Dizziness ☐ Numbness/Tingling ☐ Weakness ☐ Frequent Headaches ☐ Vision Change ☐ Choking/Difficulty
☐ Swallowing Convulsions ☐ History Of Stroke ☐ Other Neurologic Conditions:

☐ Difficulty Breathing ☐ Asthma ☐ COPD ☐ Other Lung Diseases – *Specify:*

☐ Chest Pain ☐ Atherosclerosis/Vascular Disease ☐ Arrhythmia ☐ History Of Heart Attack
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Aneurysm

☐ Loss Of Bowel/Bladder Function (☐ Stool ☐ Urine) ☐ Prostate Problems ☐ Kidney Stones/Problems
☐ Difficulty With Urination (Frequency, Urgency, Difficulty Starting Stream, Burning, Blood In Urine)

☐ Abdominal Pain ☐ Vomiting/Diarrhea ☐ Gastric/Duodenal Ulcer ☐ Pancreas Problems ☐ Liver Disease

☐ Bleeding Disorder – *Specify:* ☐ Easy Clotting – *Specify:*

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Scoliosis ☐ Ankylosing Spondylitis ☐ Osteoporosis
☐ Other Bone Disease:

☐ Down Syndrome ☐ Marfans ☐ Ehlers-Danlos

☐ Recurrent Fevers ☐ Drenching Night Sweats ☐ Weight Loss

Pain In: ☐ Neck ☐ Back ☐ Tailbone ☐ Shoulder ☐ Arm/Forearm ☐ Elbow ☐ Wrist ☐ TMJ
☐ Hips ☐ Knees ☐ Ankles/Feet ☐ Other:

☐ History Of Cancer – *Type:*

Women: ☐ Painful Periods ☐ Excessive Flow ☐ Cramping ☐ Hot Flashes

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Patient Information

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Vascular Disease/Heart Attack ☐ Cancer ☐ Stroke

☐ Other _____

Chiropractic Information

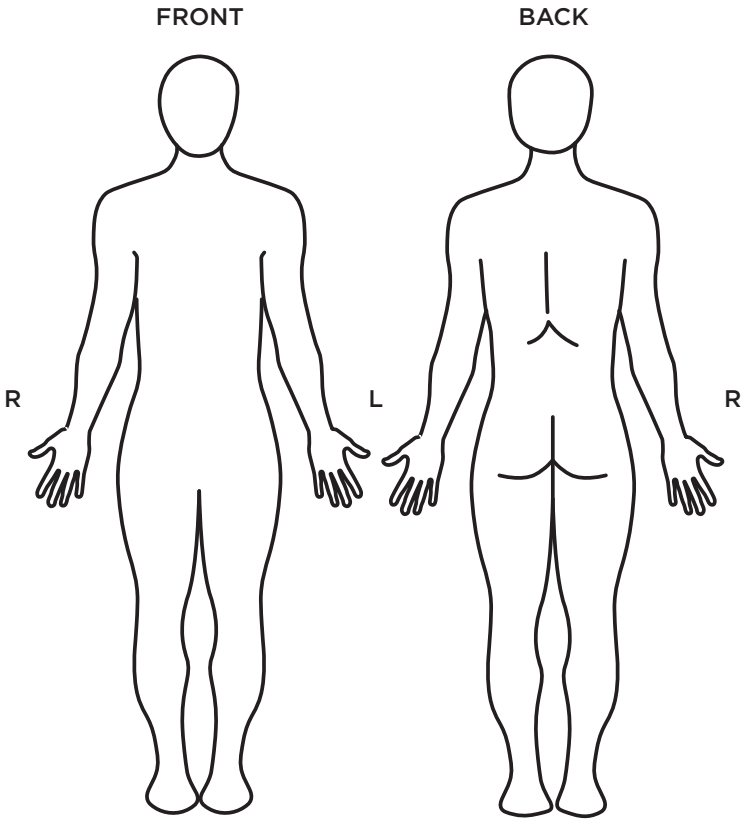
What is the reason for seeking care today: _____

Is this related to: ☐ Recent Motor Vehicle Accident ☐ Work-Related Injury/Accident (WSIB)

Have you had an X-Ray for this problem? ☐ Yes ☐ No – *When?* _____

Have you seen a chiropractor before for this condition? ☐ Yes ☐ No

Please mark all the areas of the body where you feel are painful or problematic



Patient Declaration

All of the above health information is complete and correct to the best of my knowledge. I understand that omitting health information may be dangerous to my health.

Signature: _____ Date: _____