ADVANCED THERAPEUTIC CENTRE

TORONTO, ONTARIO, M5C 1B5
TEL: 416-361-9900
FAX: 416-361-1167

INTAKE FORMS

DIAGNOSTIC CODE:

Name:_____

Address:_____

City:_____

Postal Code:_____

Date of Birth: Day_____ Month _____Year _____ Age: _____ Gender: _____

Telephone: Home ( ) - Other ( ) -

E-mail Address:_____

Occupation:_____

Marital Status:_____ Number of Children:_____

Family Physician:_____ Date of last physical exam:_____

Have you had X-rays/CT Scans/MRI in the past 3 to 6 months?_____

Do you smoke?_____ If yes, how many per day?_____

Medical/Family History_____

Have you had previous Chiropractic therapy, physiotherapy, naturopathy, other?_____

If yes, by whom?_____ Last chiropractic visit?_____

How did you hear about us?_____

If you have Extended Health Care Insurance, please check your plan.

HEALTH HISTORY

Purpose of this appointment:_____

Have you been treated for this condition before?_____

How long have you had this condition?_____

This condition began: suddenly_____ gradually_____

What makes the condition feel better:_____

The pain/health condition is **decreased** with: sitting__ standing__ bending__
lying down__ walking__ heat__ ice__

What makes the condition feel worse:_____

The pain/health condition is **increased** with: sitting__ standing__ bending__
lying down__ walking__ heat__ ice__

I sleep on my: back:__ side__ stomach__

I sleep on a: firm mattress__ soft mattress__ waterbed__ futon__

I sleep with: _____ pillow(s) under my head; _____ pillow(s) under my knees

How would you describe your pain/health condition:_____

How would you rate your pain/health condition: 1 2 3 4 5 6 7 8 9 10
(low) (moderate) (intense) (high)

The condition is: getting better___ getting worse___ staying same___ comes and goes___

The condition interferes with: work__ sleep__ daily routines__

Other complaints: _____

Sports/Exercise history:_____

Describe a typical day at work:_____

Do you wear orthotics?_____If yes, how long have you had them_____

List of Medications and Supplements:_____

Any cortisol injections? Yes____, how many and where? _____ No_____

List of any accidents, falls, fractures:_____

Is this condition the result of a motor vehicle accident or injury at work? _____

If yes, date of accident: _____

For Women Only: Is there a chance that you may be pregnant now?_____

GENERAL HEALTH INFORMATION

Please respond to all questions and/or discuss with the doctor.

	YES	NO
1. Do you have a heart pacemaker?	☐	☐
2. Do you have epilepsy?	☐	☐
3. If you are female, is there a chance you may be pregnant?	☐	☐
4. Have you ever been diagnosed with cancer?	☐	☐
5. Have you had chemotherapy/radiotherapy in the last 3 months?	☐	☐
6. Do you have any active bleeding (i.e. hemorrhage)?	☐	☐
7. Do you have any inflammation of your veins (i.e. phlebitis)?	☐	☐
8. Are you taking any immune suppressant drugs?	☐	☐
9. Do you have any form of a heart condition or beat irregularity?	☐	☐
10. Have you had a cortisone injection in the last 30 days?	☐	☐
11. Are you taking any blood thinning medicine (i.e. anti-coagulant)?	☐	☐
12. Are you using any anti-inflammatory medicine?	☐	☐
13. Are you using any anti-inflammatory ointments?	☐	☐
14. Do you have any skin sensitivity to sunlight or medicine?	☐	☐
15. Do you have any form of metal implants in your body?	☐	☐
16. Do you have any form of plastic implants in your body?	☐	☐
17. Are you presently having any other therapy?	☐	☐

SYSTEMS REVIEW FORM

Instructions: In order for us to have a complete case history and to better assess your overall health we would like you to fill out the following systems review. Please place a check beside any of the following heath and illness related points and answer the questions at the end.

Insulin Resistance/Diabetes
___ Often feel thirsty
___ Often feel hungry
___ Crave sweets or Carbohydrates
___ Have high blood pressure
___ Have high blood sugar
___ Overweight
___ Family history of Diabetes
___ Hands and/or feet go numb

Genitourinary Health
___ Frequent urination
___ Painful//Burning Urination
___ Cloudy/Odd colored Urine
___ Frequent Urinary Tract Infections
___ Foul smelling Urine
___ Suffer from bladder incontinence
___ Diagnosed with Kidney Disease

Pathological Process
___ Family history of cancer
___ Have/had cancer
___ Pain which wakes you at night
___ Sudden/Unexplained weight loss
___ Low grade fever
___ Recent open skin wound/slow healing
___ Frequent use of needles (injections)

General Health
___ I find I often eat on the run (>3x a week)
___ I always feel stressed
___ I feel fatigues and have low energy
___ Sleep is not restful and wake up tired
___ Exercise regularly (>3x a week)
___ Ingest 5-10 fruits & vegetables per day
___ Drink 6-8 glasses of water per day
___ Frequent colds

Cardiovascular Health
___ Have a heart condition
___ Experience pain with exertion
___ Irregular heart beat
___ Calf muscles cramp with walking
___ Have high cholesterol
___ Family history of high cholesterol
___ Swelling in both ankles/feet
___ Suffer with asthma
___ Have environmental/seasonal allergies
___ Frequent bronchitis/pneumonia
___ Difficulty breathing/shortness of breath
___ Chronic cough

Musculoskeletal Health
___ Have arthritis
___ Decreased Bone Mass (Osteoporosis)
___ Achy muscles/muscle spasms
___ Damaged joints, ligaments or tendons
___ Swollen painful joints
___ Tired, painful feet
___ Decreased mobility/flexibility
___ Decreased strength (joint/muscles)
___ Past injuries (car accidents, falls, sprains or strains)
___ Often fracture bones

Gastrointestinal Health
___ Suffer with stomach ulcers
___ Painful/upset stomach
___ Frequent use of antacid
___ Frequent heartburn
___ Frequent diarrhea
___ Frequent constipation (<1 bowel movement a day)

Gastrointestinal Health (con't)

___ Painful abdomen after fatty meal
___ Have blood in my stools
___ Irritable Bowel Syndrome
___ Stools float in the toilet
___ Diagnosed with Crohn's Disease
___ Diagnosed with Ulcerative Colitis
___ Diagnosed with Diverticular Disease
___ Excess bowel gas
___ Food allergies
___ Sensitive skin, rashes or other skin condition

Reproductive System (Males)
(This Section for Males Only)

___ Frequent Urination
___ Dribbling after urination
___ Difficulty urinating
___ Wake up at night to urinate
___ Diagnosed with an enlarge prostate
___ Family history of Prostate Disease
___ Low sex drive
___ Erectile dysfunction
___ Painful ejaculation

Emotional Health

___ I feel nervous
___ I feel anxious
___ Difficulty making decisions
___ Difficulty working under pressure
___ Poor memory and/or concentration
___ Moods of depression, "blues" or melancholy
___ Highly emotional

Reproductive System (Females)
(This Section for Females Only)

___ Suffer with PMS
___ Have/Had a condition of the breast
___ Family history of breast cancer
___ Use the birth control pill
___ Use Estrogen Replacement Therapy
___ Heavy menstrual period
___ Frequent mood swings
___ Menopausal/Perimenopausal
___ Experience painful intercourse
___ Diagnosed with Endometriosis
___ Diagnosed with Pelvic Inflammatory Disease
___ Low sex drive

Please answer the following:

Please list any of the above signs, symptoms or conditions which are of particular concern to you.

_____
_____
_____

Are you currently using any medication or nutritional supplementation for any of these condition/s?

Yes ____ No ____

Would you be interested in nutritional management of any of these conditions that you checked off?

Yes ____ No ____

Do you know of any family members or friends who may suffer with any of the above mentioned signs, symptoms or conditions?

Yes ____ No ____

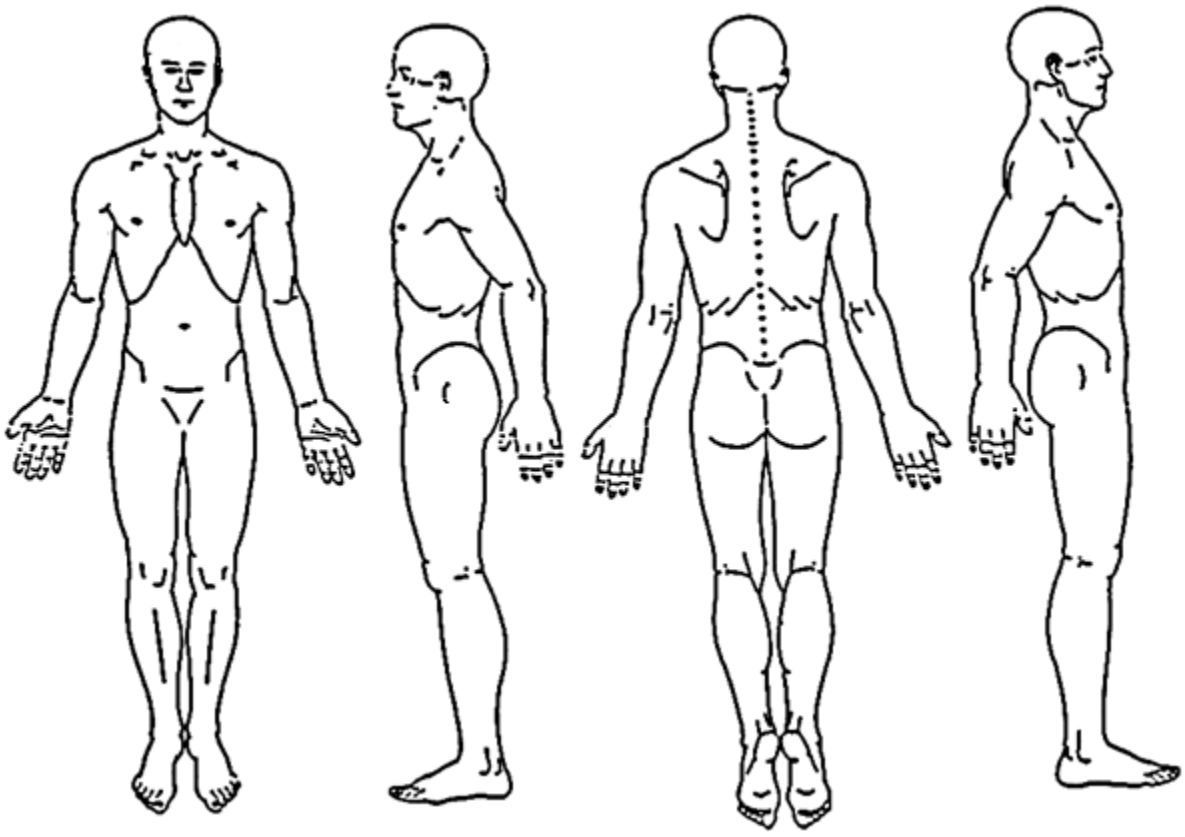
Advanced Therapeutic Centre

PAIN DRAWING

DATE: _____ NAME: _____

Using the following descriptive symbols, draw the location of your pain on the body outlines below.
In addition, mark the level of your pain on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	= = = =	**0000**	••••••••••	//////////	XXXX
^^^	= = =	**000**	•••••••••	///////	XXX



No Pain ——————————— Worst Possible Pain

Please make a slash through this line as to the level of you pain.

_____
Patient Signature