Powerflow Chiropractic Patient Application Form

CONFIDENTIAL PATIENT INFORMATION

Last Name: ______________ First Name: ______________ Middle Initial: ______________

Gender: Male / Female Date of Birth: (mm/dd/yy) __________ Age ______ Marital Status: M S D W

Phone Numbers: Home (____) ____ - ______ Cell (____) ____ - _____ Work (____) ____ - ______

E-mail: ______________________________ Do you prefer contact by text or email? ______________

Address: ______________________________ City: ______________ Postal: ______________

# of Children______ Occupation: ______________

Who referred you to our office? ( ) Family/Friend: Name: ______________ ( )TV ( ) Voice ( ) Google ( ) Walk-by

Have you ever received Chiropractic care? ☐ Yes ☐ No

Do you have Extended Health Insurance Coverage: ☐ Yes ☐ No

Do you have a current ☐MVA ☐WSIB claim? Are you currently working with a lawyer? ☐ Yes ☐ No

Do you do Exercise: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

LIST YOUR HEALTH CONCERNS BELOW:

Health concerns: List according to severity	Rate of severity 1=mild 10=unbearable	When did this Episode start?	If you had Condition before, When?	Did the problem begin with an Injury?	Are symptoms constant or Intermittent?
1.					
2.					
3.					
4.					
5.					

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS
HEADACHES
VERTIGO
INFERTILITY
NAUSEA
TMJ
NECK PAIN
MIGRANES
ANXIETY

LOW ENERGY
THYROID PROBLEMS
ASTHMA
POOR MEMORY
FIBROMYALGIA
CHEST PAIN
MENSTRUAL ISSUES
HEART DISORDERS
STOMACH DISORDERS

POOR IMMUNITY
MIDBACK PAIN
IRRITABLE BOWEL
SCIATICA
NUMBNESS IN ARMS
NUMBNESS IN HANDS
LOW BACK PAIN
HIP PAIN
LEG PAIN

CONSTIPATION
SHOULDER PAIN
CHRONICFATIGUE
POOR SLEEP
ACID REFLUX
BLADDER ISSUE
ARM PAIN
ADD/ADHD
KNEE PAIN

NERVOUSNESS
POOR FOCUS
DISC PROBLEM
EAR INFECTIONS
NUMBNESS IN LEGS
NUMBNESS IN FEET
CHRONIC SINUS
OTHER __________
____

If you take any pills, drugs or vitamins, please list: ______________________________

Please list all surgeries and date: ______________________________

History of Physical, Chemical, Emotional Stress (e.g. car accidents, injuries, falls, smoking/drinking, loss of job)
____

By signing below – I acknowledge all information is true and give Dr. Sandy Bhasin and his exam assistant full permission to carry out any exam of my spine and nerve system use of scanning technology.

Patient's Signature______________________________ Date______________

Staff Signature______________________________ Date______________

Dr Sandy's Signature______________________________ Date______________

WHAT DAILY ACTIVITIES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS?

carrying/lifting groceries	sweeping/vacuum	reading/concentration	sleep
sitting to standing	extended computer use	dressing	driving
garbage	static sitting	lifting children	shaving
pet care	climbing stairs	yard work	walking
bathing	laundry	dishes	career/job

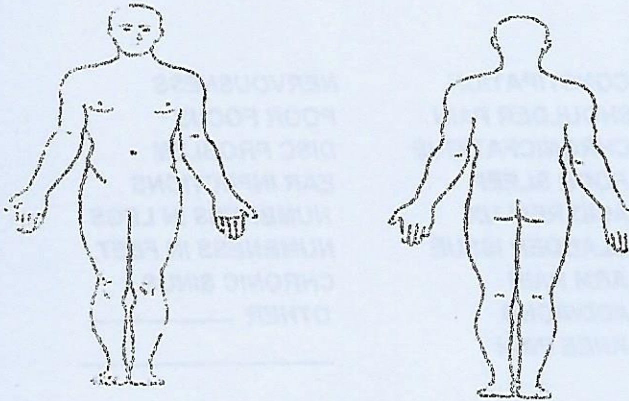
HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO

HAVE YOU EVER FRACTURED A BONE? YES / NO

PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:
R=Radiating B=Burning D=dull A=Aching N=Numbness
S=Sharp/Stabbing T=Tingling

What relieves your symptoms? ______________________________

What makes them feel worse? ______________________________



1. Do you feel as time passes you are: A. Better B. Same C. Worse
2. Is this impacting you: A. Professionally B. Personally
3. Looking at your complete health what score you give yourself out of 100? (eg.100 being the best) ______________
4. How committed are you out of 100 to get well and improve your body health without depending on drugs and surgery? (eg.100 being the best) ______________