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: Cell: (____) ____ **-** _______ **Home: (____)** ____ **-** _____

E-mail: ____________________________________

Address: ____ **City:** _______________ **Postal:** _______________________

 # Of Children_____ **Occupation:** _______________

Who referred you to our office? ( ) Family/Friend: Name: _______________________ **( )Google or ( ) 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

LIST YOUR PRIMARY HEALTH CONCERN BELOW:

____

____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	LOW ENERGY	POOR IMMUNITY	CONSTIPATION	MENSTRUAL ISSUES
HEADACHES	THYROID	MIDBACK PAIN	SHOULDER PAIN	NUMBNESS IN ARMS
VERTIGO	ASTHMA	DISC PROBLEM	CHRONIC FATIGUE	IRRITABLE BOWEL
INFERTILITY	POOR MEMORY	SCIATICA	POOR SLEEP	EAR INFECTIONS
NAUSEA	FIBROMYALGIA	ACID REFLUX	POOR FOCUS	NUMBNESS IN LEGS
TMJ	CHEST PAIN	ARM PAIN	BLADDER ISSUE	NUMBNESS IN FEET
NECK PAIN	NERVOUSNESS	LOW BACK PAIN	CHRONIC SINUS	NUMBNESS IN HANDS
MIGRANES	HEART ISSUES	HIP PAIN	KNEE PAIN	OTHER _____________
ANXIETY	STOMACH ISSUES	LEG PAIN	UPPER BACK PAIN	

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**____

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

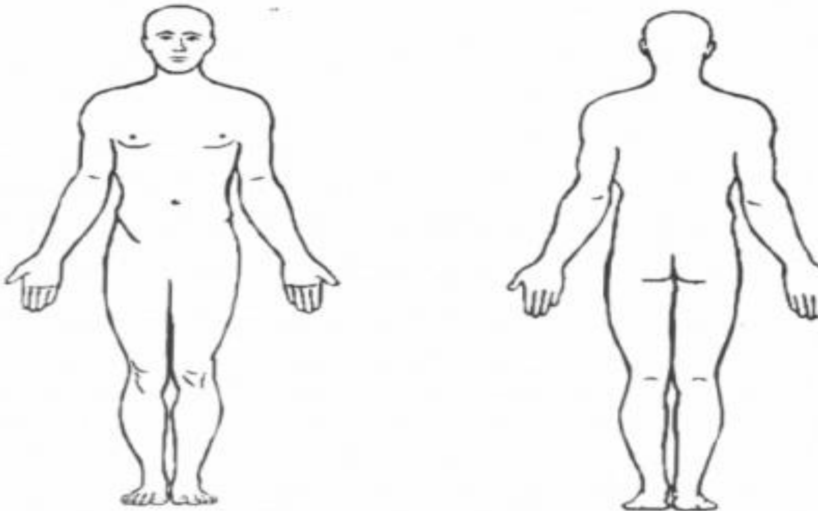
Carrying/lifting groceries	**Sweeping/vacuum**	**Reading/concentration**	**Sleep**
Sitting to standing	**Extended computer use**	**Dressing**	**Driving**
Garbage	**Static sitting**	**Lifting children**	**Shaving**
Pet care	**Climbing stairs**	**Yard work**	**Walking**
Bathing	**Laundry**	**Dishes**	**Career/job**

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 you 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 overall health what score you give yourself out of 100?**
   (Eg.100 being the best) ______________________