



Bayview North Family Chiropractic

"Take care of your body and it will take care of you"

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: ____ / ____ / ____ Gender: M F Marital Status: S M D W No. of Children: _____
Month Day Year

Tel #: Res: (____) _____ Cell: (____) _____ Bus: (____) _____

Occupation: _____ e-mail: _____

Who referred you to our clinic? _____

What health issues have brought you here today? (Check one or more)

Wellness Consult Spinal Check-up Back Pain Neck Pain Leg Pain Headache Other _____

YOUR HEALTH PROFILE

Have you been to a Chiropractor previously? Yes When: _____ Doctor: _____
No

WHY THIS IS IMPORTANT:

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our first goal is to address the issues that brought you here and secondly, to offer you the opportunity of continually improving your health and wellness. Stresses can accumulate over many years and affect your health. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime:

CHILDHOOD (to age 17)

Did you have any serious falls?
Did you play contact sports?
Did you have any surgery?
Were you involved in any car accidents?
Was there any prolonged use of medicine (e.g. Inhaler, Antibiotic)?
Were you under Chiropractic care as a child?

	Y	N	UNSURE
Did you have any serious falls?			
Did you play contact sports?			
Did you have any surgery?			
Were you involved in any car accidents?			
Was there any prolonged use of medicine (e.g. Inhaler, Antibiotic)?			
Were you under Chiropractic care as a child?			

ADULTHOOD (18 to present)

Do/did you smoke?
Do/did you drink alcohol?
Have you had any surgery?
Were you involved in any accidents (car or work)?
Is there any prolonged use of medicine (e.g. Inhaler, Antibiotics)?

	Y	N	UNSURE
Do/did you smoke?			
Do/did you drink alcohol?			
Have you had any surgery?			
Were you involved in any accidents (car or work)?			
Is there any prolonged use of medicine (e.g. Inhaler, Antibiotics)?			

On a scale of 1 to 10, describe your stress level (circle one).

Personal:	1	2	3	4	5	6	7	8	9	10
------------------	---	---	---	---	---	---	---	---	---	----

Occupational:	1	2	3	4	5	6	7	8	9	10
----------------------	---	---	---	---	---	---	---	---	---	----

On a scale of Poor, Good or Excellent, describe your:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

Do you take medications regularly for:

Heart Depression Diabetes Pain Arthritis Sleep Other _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR CLINIC

If you are experiencing pain, is it:

- Sharp Dull Constant Intermittent Radiating Other _____

Did it occur: Suddenly Gradually

How would you rate your pain on a scale of 1 – 10 (circle one).

Mild	1	2	3	4	5	6	7	8	9	10	Severe
------	---	---	---	---	---	---	---	---	---	----	--------

Since the problem started, is it: About the same Getting Better Getting Worse

What makes it worse? _____

Does it interfere with:

- Work Sleep Walking Sitting Hobbies Leisure Other _____

Other Doctors/Therapists seen for **this** problem (please list):

Chiropractor: _____

Medical Doctor: _____

Other: _____

Please check the conditions for which you have been treated:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Sinus Conditions | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stroke | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Broken Bones |

**Our clinic is dedicated to assisting you in recovering your health naturally.
Please review the next paragraph and sign in the area provided.**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment to the clinic and that that all fees are due at time of service.

I hereby request and consent to the performance of Chiropractic examinations, adjustments and other Chiropractic procedures such as, but not limited to orthotics, nutrition and lifestyle recommendations and diagnostic x-rays if necessary by the Doctor of Chiropractic named below. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of Chiropractic there are some very slight risks to treatment, including but not limited to, muscle sprains and strains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read the above and consent. By signing below I agree to the above mentioned chiropractic procedures and policies. I intend this Consent Form to cover the entire course of care at this office.

Signature _____ Date _____ Witness _____



Dr. Haydene Lee
Bayview North Family Chiropractic
9019 Bayview Avenue, Unit 2A, Richmond Hill, Ontario, L4B 3M6
905.881.8733 www.bayviewnorth.com