Bayview North Family Chiropractic
9019 Bayview Avenue, Unit 2a, Richmond Hill, ON, L4B 3M6
905.881.8733 |health@bayviewnorth.com | www.bayviewnorth.com

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

Name: Date:

Birthdate (mm/dd/yy): Age: Gender: M F Marital Status: S M D W

Home address: City: Postal Code:

Telephone nos: Home: (______)_________________ Cell: (______)___________________ Business : (______)________________

Email : ____ Occupation: ______________________________________

No. and ages of Children: _______________________________________

Emergency contact:_______________________________ Relationship:____________________ Phone: (______)_______________

Medical Doctor: ____________________ MD phone: (______)_______________ Reason for last visit:__________________________

How did you hear about our clinic? ____

YOUR HEALTH PROFILE

Have you been to a Chiropractor before: ☐ Yes ☐ No When: __________________ Chiropractor: ___________________

Is there a specific condition you would like to discuss with the doctor or is this for a general health check-up?

Explain: ____

People seek Chiropractic care for different reasons. Some want to improve their health while others want pain relief.

What are your goals? ☐ Pain relief only ☐ Correct the underlying problem ☐ Improve my overall health

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

ADULTHOOD (18 to present)	Y	N	DETAILS
Do/did you smoke?			
Do/did you drink alcohol?			
Have you had any surgery?			
Were you in any car or work accidents?			
Is there any prolonged use of medicine (e.g. inhaler, Antibiotics)?			
Do you Exercise?			

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

Please rate the following as Poor (P), Good (G) or Excellent (E):

Diet: ____________________ Exercise: ____________________ Sleep: ____________________ General Health:____________________

FOR WOMEN ONLY

Date of Last period ________________ Are you pregnant? ☐ Yes ☐ No ☐ Unsure If yes, when is your due date? __________________

# of pregnancies: __________ Menstruation: ☐ regular ☐irregular ☐ painful ☐heavy bleeding ☐ other: _________________________

GENERAL HEALTH HISTORY

Do you currently suffer from or have you suffered in the past from any of the following? Please check "√" any current issues and mark an "x" for any past issues. Circle if on the left (L) or right (R).

Musculoskeletal: Side

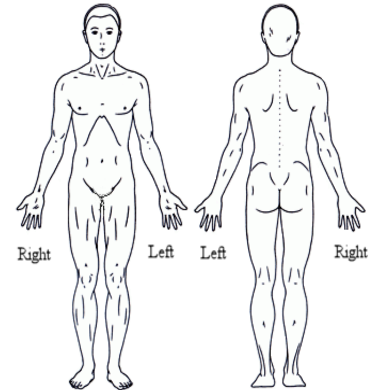
- ☐ Sore/stiff neck L R
- ☐ Sore/stiff mid back L R
- ☐ Sore/stiff low back L R
- ☐ Sore/stiff tailbone L R
- ☐ Sore/stiff TMJ (jaw) L R
- ☐ Painful/numb hand L R
- ☐ Painful/numb wrist L R
- ☐ Painful elbow L R
- ☐ Painful shoulder L R
- ☐ Painful arm/forearm L R
- ☐ Painful hip L R
- ☐ Painful knee L R
- ☐ Painful ankle/foot L R
- ☐ Other:

General Systems:

- ☐ Acne
- ☐ Allergies
- ☐ Arthritis
- ☐ Bleeding disorder
- ☐ Blood in urine
- ☐ Blurred or double vision
- ☐ Bowel/bladder issues
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Circulatory problems
- ☐ Concussions
- ☐ Constipation
- ☐ Diarrhea/Gas
- ☐ Depression or anxiety
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Dizziness
- ☐ Eating disorder
- ☐ Ear Infections
- ☐ Eczema/skin problems
- ☐ Epilepsy
- ☐ Excess hunger or thirst
- ☐ Fainting
- ☐ Food Sensitivities
- ☐ Fractures
- ☐ Heart disease
- ☐ Headaches /Migraines
- ☐ Hearing problems
- ☐ Heart attack / Angina
- ☐ Hemorrhoids
- ☐ Hepatitis A/B/C
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hot flashes
- ☐ Kidney issues
- ☐ Loss of sleep
- ☐ Loss of strength
- ☐ Low bone density
- ☐ Nausea
- ☐ Night sweats
- ☐ Numbness or tingling
- ☐ Osteoporosis
- ☐ Problems swallowing
- ☐ Prostate trouble
- ☐ Psychological disorder
- ☐ Rashes/itching
- ☐ Ringing in the ears
- ☐ Spitting blood/phlegm
- ☐ History of stroke
- ☐ Swelling of joints
- ☐ Fibrocystic breasts
- ☐ Hyper/Hypo Thyroid
- ☐ Tremors
- ☐ Varicose veins
- ☐ Vision problems
- ☐ Weak immune system
- ☐ Weight concerns

Using the following symbols, please circle on the body diagrams below the area of your complaint and the type of pain experienced.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other ______	^ ^ ^



Do you sleep on your ☐ stomach ☐ back ☐ side   Type an number of pillows you use: ______________________

Do you wear custom foot orthotics? ☐ Yes ☐ No   How long have you had them? ____________________

Please list any medications and supplements you are taking: ____

Please list the dates and details of any surgeries, hospitalizations, car accidents or other major traumas:______________________________
____

Please check if anyone in your family (parents or siblings) have any of the following:

☐ Heart Disease ☐ High Cholesterol ☐ Stroke ☐ Osteoporosis ☐ Other:
☐ Cancer ☐ High Blood Pressure ☐ Diabetes ☐ Arthritis

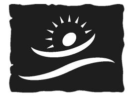
Our clinic is dedicated to assisting you in recovering your health naturally.
Please review the next paragraph and sign in the area provided.

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 understand and consent to my email address to be used to receive appointment reminders, important clinic information and occasional newsletters. I understand that I can choose to unsubscribe to clinic emails at any time.

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(s) 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, fractures, 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.

Name ____________________________ Signature ______________________ Date ____________________ Witness ________________________



Dr. Haydene Lee - Dr. Andrew Ting
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