New Sudbury Chiropractic & Wellness Centre
1100 Lasalle Blvd., Sudbury, ON. P3A 1X9
(705) 521-1100
www.newsudburychiropractic.ca

Welcome to Our Office
Outline of Procedures for New Patients

STEP ONE

All new patients are requested to fill out a confidential ***Patient Health Record***.

STEP TWO

Your first ***consultation*** with the doctor to discuss your health problems.

STEP THREE

Diagnostic chiropractic, orthopedic and neurological ***examination*** procedures to determine if chiropractic care is appropriate for your condition.

STEP FOUR

The doctor will advise you as to the need of additional procedures such as ***laboratory test and X-rays***, if necessary.

STEP FIVE

If your case requires immediate attention, ***emergency first aid treatment*** will be administered.

STEP SIX

You will be advised as to a time you can return for a ***Special Appointment***. Our records show that those patients who respond most rapidly to care are those who have learned to help themselves. We give you, your family and friends the opportunity to learn what you can do to help us return you to health more quickly and completely, and what one needs to do to stay healthy.

STEP SEVEN

You will be advised as to a time you can return for your ***Report of Findings*** when your doctor will inform you as to your examination results and whether or not your case has been accepted. If accepted your recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

STEP EIGHT

Chiropractic care will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained.

To save time and allow us to better serve you, please complete all questions on the next pages, Thank You.

New Sudbury Chiropractic and Wellness Centre 1100 Lasalle blvd. Sudbury ON. P3A 1X9 (705) 521-1100
Dr. Michael Staffen Dr. Brandon Jones

Date: Patient No.

PERSONAL HISTORY

Name: _____ Birthdate: ____/____/_____ Age: _____ Gender: ☐M ☐F
Address: _____ City: _____ Province: _____
Postal Code: _____ Home Ph: _____ Cell Ph: _____ Business Ph: _____
Family Physician's Name: _____ Extended Health Coverage: ☐ Yes ☐ No ☐ Not sure
Business/Employer: _____ Type of Work: _____
Circle one: Married Single Widowed Divorced Separated No. of Children _____
Referred To This Office By: _____
How will you be taking care of your account? ☐ Cash ☐ Cheque ☐ Debit ☐ Visa ☐ MasterCard

CURRENT HEALTH CONDITION

Current Complaint(s): _____
_____
Other doctors seen for this condition: ☐No ☐Yes: Who?_____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? ☐No ☐Yes, _____
Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: _____
Date of Accident: _____ Time of Accident: _____

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb
☐ Burning ☐ Constant ☐ Intermittent

Please describe how it feels when this problem is at its worst: _____
_____
Compare this problem at its worst and a time when you feel great. How does this problem at its worst interfere with:
Your ability to work?_____
Your ability to enjoy your family or your social time? _____
Your ability to enjoy your hobbies or sports? _____
At its worst, how old does it make you feel? _____
If you don't get this problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No
On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem. _____

List any medications you are currently taking: _____
_____
Have you ever had x-rays taken before? ☐ No ☐ Yes When and where?_____
X-ray of what?_____

PAST HEALTH HISTORY

Major Surgery/Operations : ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Hysterectomy ☐ Other: _____
Major Accidents or Falls: _____
Hospitalization (other than above): _____
Previous Chiropractic treatment: ☐ None ☐ Chiropractor's name and date of last visit:_____

FAMILY HEALTH HISTORY

Does any member of your family suffer from the same condition? ☐ No ☐ Yes ☐ Whom?_____
Have your children ever had a spinal check up? ☐ No ☐ Yes ☐ If yes, Where & When? _____

New Sudbury Chiropractic and Wellness Centre 1100 Lasalle blvd. Sudbury ON. P3A 1X9 (705) 521-1100
Dr. Michael Staffen Dr. Brandon Jones

Patient No.

Below is a list of diseases which may seem unrelated to the purpose of your appointment; however, these questions must be answered carefully as these problems can affect your overall course of chiropractic treatments.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD.

☐ Pneumonia
☐ Mumps
☐ Influenza
☐ Rheumatic Fever
☐ Small Pox
☐ Pleurisy
☐ Polio
☐ Chicken Pox
☐ Arthritis
☐ Tuberculosis
☐ Diabetes
☐ Epilepsy
☐ Whooping Cough
☐ Cancer
☐ Mental Illness
☐ Anemia
☐ Heart Disease
☐ Bleeding Disorder
☐ Hemophilia
☐ Measles
☐ Thyroid
☐ Eczema
☐ Fibromyalgia/Chronic Fatigue
☐ Colitis
☐ Alcoholism

Check any of the following you have had in the past six months.

MUSCULO-SKELETAL CODE

☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Leg Pain
☐ Knee Pain
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficulty Chewing/Clicking Jaw
☐ General Stiffness

NERVOUS SYSTEM CODE

☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness/Confusion
☐ Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Hands/Feet
☐ Always feel cold
☐ Always feel warm

C-V-R CODE

☐ Chest Pain
☐ Shortness of Breath
☐ Blood Pressure Problems
☐ Heart Problems
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke

GENERAL CODE

☐Fatigue
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches

EENT CODE

☐ Deafness
☐Earache
☐Ear ringing/buzzing
☐ Vision Problems
☐ Eye pain
☐ Nose Bleed
☐ Sinus Infection
☐ Sore throat
☐ Enlarged thyroid
☐ Tonsillitis

DIGESTIVE CODE

☐ Gas/Bloating After Meals
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Black/Bloody Stool
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Problems
☐ Gall Bladder Problems
☐ Weight Trouble
☐ Abdominal Cramps
☐ Heart Burn/Indigestion

MALE/FEMALE CODE

☐ Menstrual Cramping/Irregularity
☐ Vaginal Pain/Infections
☐ Breast Pain/Lumps
☐ Prostate/Sexual Dysfunction

GENITO-URINARY CODE

☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discoloured Urine

FEMALE ONLY

When was your last period? _____
Are you Pregnant?

☐Yes ☐No ☐Not Sure

INTAKE

☐Coffee #cups/day: _____
☐Tea #cups/day: _____
☐Alcohol Amount/day: _____
☐Cigarettes Amount/day: _____
☐Soft Drinks Amount/day: _____
☐Vitamins: If Yes what brand:
_____

PERSONAL SATISFACTION WITH DIET

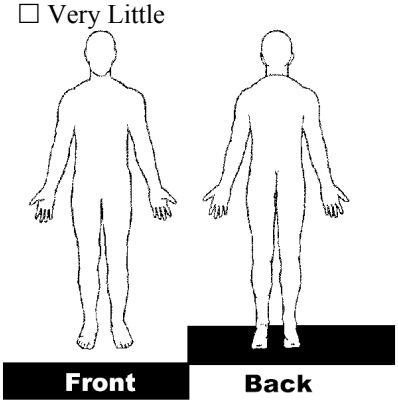
1 2 3 4 5
I---------I----------I----------I----------I
Satisfied Neutral Dissatisfied

DO YOU HAVE A REGULAR EXERCISE PROGRAM?

☐Yes ☐No
If yes, Please describe: _____
_____

LIFESTYLE STRESS LEVELS

☐High
☐ Moderate
☐ Very Little



Please outline on the diagram the area of your discomfort and any radiation of pain.