Sudbury Spine & Sport Clinic – Confidential Patient Information/Case History

Patient Information:
Name _____
Address _____
City _____ Postal Code _____
D.O.B (dd/mm/yyyy)_____ Age _____ Sex M / F

Home Telephone # _____
Work # _____
Cell # _____
Email: _____
Occupation: _____
Emergency Contact _____
Phone # _____
How did you hear about this office? _____
Whom may we thank for referring you? _____
_____

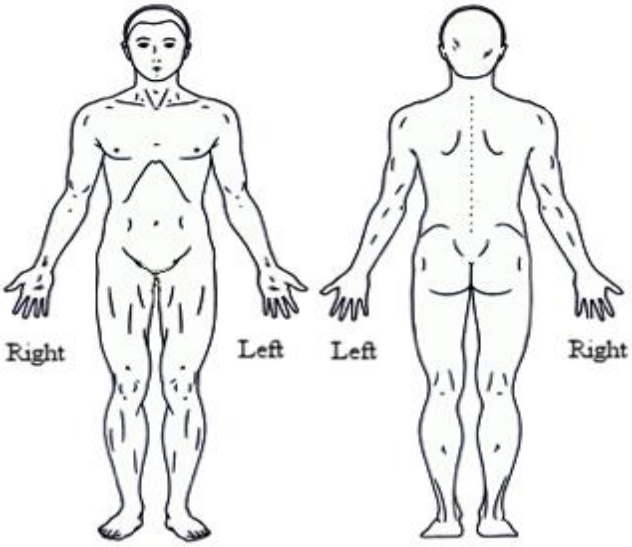
Previous Health Care:
Have you had previous chiropractic care? Yes / No

Provider's Name _____
When/Why? _____

Medical Doctor:
Name _____
Address/ Phone # _____
Date of last physical exam: _____

Did your medical doctor recommend that you seek chiropractic care? Yes / No
Is it ok if we communicate with your medical doctor regarding your health condition? Yes / No
Have you recently had x-rays or imaging? Yes / No
Date & Location: _____

Chief Complaint:
Primary Complaint _____
_____
_____
Other Complaints _____
_____
Is this condition due to a motor vehicle accident? Y / N
Is this condition due to a work related accident? Y / N
Please mark all problem areas appropriately:



Sharp /// Burning XXX Dull Ache OOO
Pins/Needles +++ Numbness •••

Please circle the degree of pain (0=None, 10=Extreme)
0 1 2 3 4 5 6 7 8 9 10

Did the problem come on: ☐ Suddenly ☐ Slowly
When (date) did this problem begin?_____
How did this problem begin (mechanism)? _____
_____
_____
_____
Have you had a similar condition before? Yes / No
If yes, when? _____
Is the pain: ☐Improving ☐Unchanging ☐Worsening
Is the pain: ☐ Constant ☐ Intermittent
When does it bother you most? _____
_____
What makes this condition better? _____
_____
What makes this condition worse? _____
_____
Does the pain radiate anywhere? If so, where? _____
_____
What treatments, medications, etc have you tried using for this condition? Did they work? _____
_____

Does this condition interfere with: ☐ Sleep ☐ Work
☐ Home life ☐ Daily Routine ☐ Recreation/exercise
Is there anything else that you think is relevant or important regarding your condition? _____
_____
_____
_____

Today's Date _____

Dr. Nicholas Staneckyj, DC
7-2140 Regent St., Sudbury, ON P3E 5S8

Sudbury Spine & Sport Clinic – Patient Health History

Name:

Please list any previous injuries, falls, motor vehicle accidents, hospitalizations or surgeries: _____

Please list any medications/vitamins that you are currently taking or have taken recently _____

Social History/Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐

...If yes, how long have you smoked for? _____

Work Activities				
Standing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Lifting	☐	☐	☐	☐

Health History - Please check off any of the following that **you** currently have or have had in the past (indicate age diagnosed):

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Vision problems
- ☐ Weight loss/gain

Muscle/ Joint
- ☐ Arthritis
- ☐ Weakness
- ☐ Back pain
- ☐ Neck pain
- ☐ Other joint pain:

_____

Skin
- ☐ Bruise easily
- ☐ Dryness/ Itching
- ☐ Hives/Rash
- ☐ Varicose veins

Eye/Ear/Nose/Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Atherosclerosis
- ☐ Chest pain
- ☐ Heart palpitation
- ☐ Poor circulation

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis/ Crohn's disease
- ☐ Constipation
- ☐ Diarrhea
- ☐ Digestion problems
- ☐ Diverticulosis
- ☐ Bloating
- ☐ Gallbladder problems
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Liver disease
- ☐ Nausea
- ☐ Painful defecation
- ☐ Vomiting of blood

Genitourinary
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Difficulty urinating
- ☐ Painful urination
- ☐ Urgency to urinate

Respiratory
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Spitting up phlegm/blood
- ☐ Wheezing

Women Only
- ☐ Breast disease
- ☐ Vaginal discharge
- ☐ Menopause

Are you currently pregnant?
☐ Yes ☐ No
If yes, how many weeks: _____
Number of children: _____
Date of last pap test:_____
☐Normal ☐Abnormal

Men Only
Have you ever had a prostate exam? ☐ Yes ☐ No
Date of last exam:_____

Health History – Please check any conditions that you have or have had and indicate the age at which you were diagnosed:

☐ Alcoholism	☐ Anemia	☐ Appendicitis	☐ Arteriosclerosis	☐ Asthma
☐ Bronchitis	☐ Cancer	☐ Diabetes	☐ Edema	☐ Emphysema
☐ Epilepsy	☐ Goiter	☐ Gout	☐ Heartburn	☐ Heart disease
☐ Hepatitis	☐ High cholesterol	☐ HIV/AIDS	☐ Miscarriage	☐ Multiple sclerosis
☐ Neurological disorder	☐ Pace maker	☐ Osteoporosis	☐ Pneumonia	☐ Polio
☐ Rheumatic fever	☐ Stroke	☐ Thyroid disease	☐ Ulcers	☐ Other _____

Family History – If any **blood relative** has had any of the following conditions, please check and indicate which relative:

☐ Arthritis	☐ Autoimmune Disease	☐ Bleeding Disorder	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ High Blood Pressure	☐ High Cholesterol	☐ Multiple Sclerosis	☐ Osteoporosis	☐ Stroke	☐ Thyroid Disease

I agree and understand that I am responsible for all charges related to my visit.

Name (please print): _____ Date: _____

Patient Signature/ Legal Guardian: _____