HURONIA CHIROPRACTIC & WELLNESS CENTRE
4-237 Mapleview Dr. E, Barrie ON L4N 0W5
705.739.1155

Dr. Stacey L. Hudson, BSc, DC
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New Patient Information

Date_____

Name_____ **Address**_____

_____
(CITY) (POSTAL CODE)

Home phone number _____**Mobile #**_____
Work phone number _____**EXT**_____
Email Address_____

Occupation_____ **Employer**_____
sex: ☐M ☐F Age_____ **Birth date**_____ **Marital Status**:_____
(day/mo/yr)

Extended Health Care Coverage (EHC)

Do we have your permission to look into your policy ☐yes ☐no
Insurance Company Name: _____
Policy #: _____ Member ID #: _____
Plan Holders Name: _____ Date of Birth: _____

Emergency Contact Info

Doctor *name:* _____ ***Phone #:*** _____
Emergency contact name: _____ Relation: _____
Home phone: _____ Work phone: _____

Whom may we thank for referring you? _____

* Patient condition

Reason for visit /Chief Complaint

IS THIS A RESULT OF: ☐ car accident (M.V.A.) ☐ work injury (W.S.I.B.)

_____
_____
_____

Your symptoms are: ☐ decreasing ☐ not changing ☐ increasing
Symptoms are worse in the: ☐ morning ☐ afternoon ☐night ☐increases during the day ☐same all day

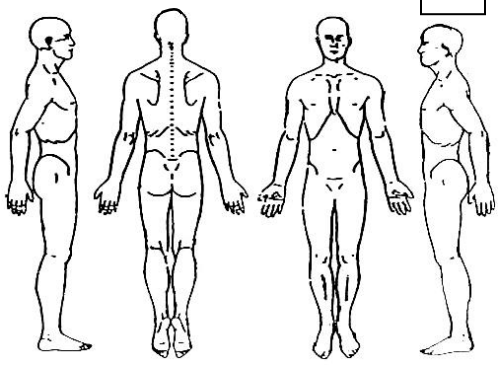
*

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ☐

Type of pain :
☐ sharp
☐ throbbing
☐ aching
☐ cramps
☐ shooting
☐ dull
☐ numb
☐ tingling
☐ weak
☐ burning

Frequency of pain:
☐constant (76-100%)
☐frequent (51-75%)
☐occasional (26-50%)

* ***Please mark on the picture where you have pain or other symptoms.***



Have you had these symptoms in the past ? ☐yes ☐no - If yes, when?_____
Does it interfere with your: ☐ work ☐sleep ☐recreation ☐daily routine

*What makes your symptoms **worse?***_____
better?_____

***Activities that are painful to perform**:*
*☐sitting ☐standing ☐twisting ☐walking ☐bending ☐lying down ☐other*_____

Health History

✱ **What treatment have you already received for your condition**? □ medications □surgery
□ physical therapy □chiropractic services □none □other□

✱ **Have you ever been to a Chiropractor?** **no** □
Yes □ → **who?** _____ **last treatment?** _____

Date of last: Physical exam _____ spinal x-ray_____ blood test_____
spinal exam _____ chest x-ray _____urine test_____
MRI, CT-scan, bone scan_____

✱ ***Please indicate if you have (by circling) or have had (by checking box) any of the following:***

	y		y		y		y
neck pain		dizziness		painful urination		emphysema	
shoulder pain		headaches		frequent urination		arthritis	
arm/elbow pain		migraines		loss- bladder control		rheumatoid arthritis	
hand/wrist pain		rapid heart beat		abdominal pain		diabetes	
jaw pain		chest pains		difficulty swallowing		epilepsy	
upper back pain		loss of appetite		heartburn/indigestion		ulcer	
lower back pain		anorexia		rash/eczema		liver/gallbladder prob	
hip pain		weight gain/loss		depression		kidney stones	
leg pain		excessive thirst		aortic aneurysm		colitis	
knee pain		chronic cough		high blood pressure		irritable colon	
foot/ankle pain		chronic sinusitis		angina		HIV/AIDS	
pinched nerve		fatigue		heart attack		systemic lupus	
stiff/swollen joints		menstrual prob.		cancer		stroke	
fainting		breast lumps		tumor		mumps	
visual disturbances		constipation		prostate problems		measles	
convulsions		diarrhea		blood disorder		chicken pox	
anemia		ringing in ears		herniated disk		multiple sclerosis	
allergies		gout		mononucleosis		pacemaker	
Varicose veins							

EXERCISE:
□ none
□ moderate
□ daily
□ heavy

WORK ACTIVITY:
□ sitting
□ standing
□ light labour
□ heavy labour

HABITS:
□ smoking- packs/day_____
□ alcohol- drinks/week_____
□ coffee/caffeine-cups/day_____
□ high stress level -reason_____

ARE YOU PREGNANT? no □ yes □ Due date _____

✱ **Injuries/surgeries you have had** **Please Describe** **Date**

note: even falls/accidents and injuries that happened a long time ago can still impact your health today. Please tell us about them.

falls/accidents_____ _____
head injuries _____ _____
broken bones _____ _____
dislocations _____ _____
surgeries _____ _____
illnesses_____ _____

MEDICATIONS **VITAMINS/HERBS/MINERALS**

_____ _____ _____
_____ _____ _____

I certify that the above information is correct to the best of my knowledge.
Patient's signature _____ **Date** _____