



in GoodHands

Rehabilitation & Wellness Centre

Inside GoodLife Fitness in Bramalea City Centre
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Welcome

You are in GoodHands.

Doctors: Dr. A. Mitha B.Sc., D.C., and
Dr. J. Eto B.Sc., B.Ed., C.Ped., D.C.

INITIAL HEALTH INTAKE FORM

Please complete all Questions

PATIENT INFORMATION

Name: _____
Address: _____
City: _____ Prov.: _____ Postal Code: _____
E-mail: _____
SIN #: _____ Date of Birth: _____
Age: _____ Sex: M F
Occupation: _____
Employer: _____
Family Member Names & Relation: _____

Is there any chance that you are pregnant? Y N
Whom can we thank for referring you? _____

PHONE NUMBERS

Work#: () _____ Cell#: () _____
Best time and place to reach you: _____

In case of emergency, contact:
Name: _____
Relationship: _____
Home#: () _____ Work#: () _____
Cell #: () _____

INSURANCE

Do you have private health insurance? Y N

CURRENT HEALTH

1. Check any of the following symptoms you may have experienced in the past six months:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> low back pain | <input type="checkbox"/> flat feet | <input type="checkbox"/> allergies | <input type="checkbox"/> cancer |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> shin splints | <input type="checkbox"/> digestive problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> elbow pain | <input type="checkbox"/> tired / fatigue | <input type="checkbox"/> ankle / foot pain | <input type="checkbox"/> asthma |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> ringing in the ears | <input type="checkbox"/> wrist / hand pain | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> knee pain | <input type="checkbox"/> weight loss | <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> obesity | <input type="checkbox"/> heart disease | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> achilles tendinitis | <input type="checkbox"/> calluses / bunions | <input type="checkbox"/> pain between the shoulder blades | |
| <input type="checkbox"/> numbing or tingling in arms / hands | | <input type="checkbox"/> numbing or tingling in legs / feet | |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> headaches | <input type="checkbox"/> tension across the top of shoulders | |

Which of the above is the worst? _____ How long have you had it? _____
When is it at its worst? _____ How does it feel? _____

2. Do these symptoms cause you to at times be

- moody interrupted sleep
 irritable restricted in daily activities

3. Do these symptoms affect your

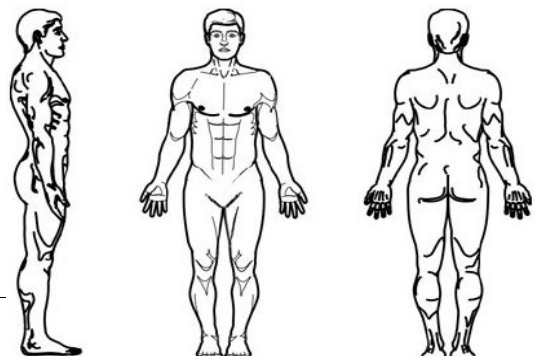
- work
 poor attitude
 decision making
 decreased productiveness
 exhausted at end of the day
 unable to work long hours

4. Do these symptoms affect your life?

- Do you lose patience with your partner or children?
 Are you restricted in doing your household duties?
 Are they hindering your ability to exercise or participate in sports?
 Are they interfering with your ability to participate in any other desired activities?

Use the following symbols to mark your areas of discomfort on the diagram below. i.e.: if you have a severe burning feeling, you will place a "+" and a "3" beside the appropriate area on the diagram.

- + Burning pain 1 Mild
- = Dull pain 2 Moderate
- * Stabbing pain 3 Severe
- Sharp pain



HEALTH HISTORY

1. Growth and development

If yes, date

Surgery? Y N _____
Medications? Y N _____
Accidents? Y N _____
Did you have other traumas? (i.e.. fall down stairs, etc.) Y N _____

2. Current health history

Did / do you smoke? Y N _____
Did / do you drink any alcohol? Y N _____
Have you been in a car accident? Y N _____
Have you had an organ removed or replaced? Y N _____
Drugs? (prescription or non prescription) Y N _____
Eye problems? Y N _____
Hearing problems? Y N _____
Did/do you have occupational stress? Y N _____
Hobbies / sport injuries? Y N _____
Exercise regularly? Y N _____
Diet (do you eat healthy foods?) Y N _____

What is your sleeping posture? side stomach back

When dealing with a health issue, how do you get rid of the problem?

Only symptomatic relief Symptomatic relief and prevention of re-occurrence
 Symptomatic relief, prevention of re-occurrence and achievement of optimal wellness

Have you ever received chiropractic care? Y N

If yes, may we have the name and phone number of your previous chiropractor?

Chiropractor's name: _____ Phone#: () _____ Date of last visit: _____

OTHER

To help us better explain chiropractic and how we may be able to help you, please check the one best answer for each statement below:

1. I remember important things in my life by what I:

Feel See Hear All of the above

2. The primary reason I brush my teeth is:

To avoid tooth decay and gum disease To have healthy teeth/gums
 To have healthy teeth/gums To have nice looking teeth and gums

3. When I make a decision I generally...

Gather the facts and weigh the evidence Make the right choice instantly
 Consult my friends and family Depends on how I feel about it

4. When I get in an automobile, I put on my seat belt

Everytime Most of the time Some of the time Never

What do you look for in a Good Doctor? _____

How is your health compared to last year? Same Better Worse

The Above Information is True and Accurate to the Best of my Knowledge

Print Name

Signature

Date