



In GreatHands

Chiropractic & Wellness Centre

Inside Oshawa Centre Mall
C/O Goodlife, 419 King Street West, Oshawa, ON L1J 2K5
Phone: (905) 433-9520 Fax: (905) 433-8144
Email: oshawa@ingreathands.com Website: www.ingreathands.com

Welcome

You are in GreatHands.

Doctors: Dr. A. Shariff, D.C. and
Dr. A. Rodrigues, D.C.

INITIAL HEALTH INTAKE FORM

Answering the following questions will give us an idea of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

PATIENT INFORMATION

Name: _____
Address: _____
City: _____ Prov.: _____ Postal Code: _____
E-mail: _____
SIN #: _____
Driver's License #: _____
Date of Birth: _____ Age: _____ Sex: M F
 Single Married Divorced Widowed
 # of Children: _____
Occupation: _____
Business/Employer: _____
Is there any chance that you are pregnant? Y N
How did you hear about our office? (if someone referred you, please let us know so that we can thank them!) _____

PHONE NUMBERS

Home#: () _____ Cell#: () _____
Work#: () _____ Ext. _____
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

Insurance Provider: _____
Policy #: _____
ID #: _____

CURRENT HEALTH

1. Check any of the following symptoms you have had in the last 12 months, even if they do not seem related to your current problem.

- | | | | |
|--|--|--|---|
| <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 /pacemaker | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> achilles tendonitis | <input type="checkbox"/> calluses / bunions | <input type="checkbox"/> pain between the shoulder blades | |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> headaches / migraines | <input type="checkbox"/> tension across the top of shoulders | |
| <input type="checkbox"/> numbing or tingling in arms / hands | | | |

Which of the above is the worst? _____ How long have you had it? _____

When is it at its worst? _____

How does it feel? (sharp / dull / achy / pins & needles / numbness) _____

2. Do these symptoms interfere with your

- | | | |
|----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> work | <input type="checkbox"/> sleep | <input type="checkbox"/> walking |
| <input type="checkbox"/> sitting | <input type="checkbox"/> hobbies | <input type="checkbox"/> leisure |

3. Other professionals you have seen for this problem:

- | | | |
|---------------------------------------|--|-----------------------------|
| <input type="checkbox"/> chiropractor | <input type="checkbox"/> physiotherapist | <input type="checkbox"/> MD |
| <input type="checkbox"/> other _____ | | |

Is this condition: Job related / WSIB Motor Vehicle Accident

(If you have marked either of these two options, PLEASE INFORM THE FRONT DESK)

Mark where the problem is on the diagram with an X or a circle, and please describe what it feels like.

Sharp / Dull / Achy / Stabbing



