



In Great Hands

Chiropractic & Wellness Centre

Inside Oshawa Centre Mall
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Welcome

You are in GoodHands.

Doctor: Dr. David W. Sloan

NATURAL MEDICINE 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: <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
<input type="checkbox"/> # of Children: _____
Occupation: _____
Business/Employer: _____
Is there any chance that you are pregnant? <input type="checkbox"/> Y <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> 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 _____
Do you consent to progress reports to your Family Physician with updates on your condition? <input type="checkbox"/> Y <input type="checkbox"/> N

HEALTH HISTORY

Main complaint: _____
Symptoms: _____
Digestive problems: _____
Elimination problems: _____
Previous treatment: _____
Diet: _____
Remarks: _____

Allergies / sensitivities:	Current prescription medications:	Current over-the-counter medications:	Current vitamin/mineral formulations:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

By Signing the Following, I Agree that the Above Information is True and Accurate to the Best of my Knowledge

Print Name

Signature

Date