ROSENBERG CHIROPRACTIC CLINIC

DR. PAUL S. ROSENBERG

4202 Dundas St W, Toronto, ON M8X 1Y6

Welcome to **Rosenberg Chiropractic Clinic**. Please complete this confidential questionnaire to the best of your ability. Your answers will determine how chiropractic can best help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

PLEASE PRINT

Name: _____

Address: _____ Suite # _____ City _____ Postal Code _____

Home Phone: _____ Bus Phone: _____ Cell Phone: _____

Email address: _____ **(You authorize this office to email reminders and/or notices to you.)**

Birth Date: _____ Age: _____ Gender: _____ Married/Single _____ No. of Children _____
(day) (month) (year)

Occupation: _____ Is this a work related injury? Yes ____ No ____

Is this related to a motor vehicle accident? Yes ___ No ____ If yes; date of accident: _____

Do you have extended health care coverage which covers chiropractic treatment? Yes _____ No ____
If Yes, name of Insurance Co: _____

Physican's Name: _____
What brings you in to our office today? _____
Who referred you to our office? _____

I understand, all information given is strictly confidential. No information can be collected, used or disclosed outside of this office unless authorized by me or my guardian. If you require a reminder call and you are not available to answer, we will leave a message stating date and time of appointment unless you request otherwise. Please note, if you have provided an email address it will not be shared with anyone outside of this office.

Signature: _____ **Date:** _____

Health History

Please check the conditions that you have experienced or that you are currently experiencing.

Have you ever had chiropractic care? Y N
If yes; date of last care & name of previous chiropractor,
_____

How long has it been since you had;
Complete physical exam _____
Heart exam _____
Blood pressure check _____
Spinal x-rays _____

Have you ever been hospitalized or had surgery ? Y N
If yes, please explain; _____
_____
_____

Are you taking any medication? Y N
If yes, what type _____
_____

Have you ever had any mental disorders? Y N
Have you ever had a nervous breakdown? Y N
Is there any physical or mental illness in your family? Y N
If yes, type/s _____

SYMPTOMS
(Leave blank if not applicable)

GENERAL	Mild	Medium	Severe
Chills	☐	☐	☐
Fever	☐	☐	☐
Convulsions	☐	☐	☐
Dizziness	☐	☐	☐
Fainting	☐	☐	☐
Fatigue	☐	☐	☐
Headaches	☐	☐	☐
Insomnia	☐	☐	☐
Loss of weight	☐	☐	☐
Nervousness	☐	☐	☐
Tremors	☐	☐	☐
Numbness	☐	☐	☐
Weakness of Arms/Legs	☐	☐	☐

continued on other side . . .

(Leave blank if not applicable)

MUSCLE & JOINT	Mild	Medium	Severe
Arthritis	☐	☐	☐
Swollen joints	☐	☐	☐
Neck pain	☐	☐	☐
Neck stiffness	☐	☐	☐
Mid back pain	☐	☐	☐
Mid back stiffness	☐	☐	☐
Low back pain	☐	☐	☐
Low back stiffness	☐	☐	☐
Foot pain	☐	☐	☐
Ankle pain	☐	☐	☐
Knee pain	☐	☐	☐
Hip pain	☐	☐	☐
Hand pain	☐	☐	☐
Elbow pain	☐	☐	☐
Shoulder pain	☐	☐	☐
Hernia	☐	☐	☐

CARDIOVASCULAR			
Chest pain	☐	☐	☐
Heart disease	☐	☐	☐
Hardening of Arteries	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Poor circulation	☐	☐	☐
Stroke	☐	☐	☐
Rapid beating heart	☐	☐	☐
Slow beating heart	☐	☐	☐
Swollen ankles	☐	☐	☐
Varicose veins	☐	☐	☐

RESPIRATORY			
Allergies	☐	☐	☐
Asthma	☐	☐	☐
Difficulty breathing	☐	☐	☐
Wheezing	☐	☐	☐
Chest pain	☐	☐	☐
Chronic cough	☐	☐	☐
Frequent colds	☐	☐	☐
Spitting up blood	☐	☐	☐
Spitting up Phlegm	☐	☐	☐

SKIN			
Boils	☐	☐	☐
Bruises	☐	☐	☐
Dryness	☐	☐	☐
Eczema	☐	☐	☐
Hives	☐	☐	☐
Itching	☐	☐	☐
Sensitive skin	☐	☐	☐
Skin eruptions	☐	☐	☐

GENITO-URINARY			
Blood in urine	☐	☐	☐
Frequent urination	☐	☐	☐
Inability to control urine	☐	☐	☐
Kidney infection	☐	☐	☐
Kidney stone	☐	☐	☐
Painful urination	☐	☐	☐
Prostate trouble	☐	☐	☐
Venereal infection	☐	☐	☐

E.E.N.T.	Mild	Medium	Severe
Deafness	☐	☐	☐
Dental decay	☐	☐	☐
Gum trouble	☐	☐	☐
Earache	☐	☐	☐
Ear noises/ringing	☐	☐	☐
Enlarged glands	☐	☐	☐
Enlarged thyroid	☐	☐	☐
Eye pain	☐	☐	☐
Hay fever	☐	☐	☐
Nasal congestion	☐	☐	☐
Nose bleeds	☐	☐	☐
Sinus infection	☐	☐	☐
Sore throat	☐	☐	☐
Tonsillitis	☐	☐	☐

GASTRO-INTESTINAL			
Appendicitis	☐	☐	☐
Belching or Gas	☐	☐	☐
Colitis	☐	☐	☐
Colon trouble	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Difficult digestion	☐	☐	☐
Poor appetite	☐	☐	☐
Excessive hunger	☐	☐	☐
Gall bladder trouble	☐	☐	☐
Hemorrhoids	☐	☐	☐
Jaundice	☐	☐	☐
Liver trouble	☐	☐	☐
Nausea	☐	☐	☐
Recent Vomiting	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/HIV positive	Y	N	Alcoholism/Drug addiction	Y	N
Anemia	Y	N	Appendicitis	Y	N
Cancer	Y	N	Diabetes	Y	N
Epilepsy	Y	N	Malaria	Y	N
Pleurisy	Y	N	Pneumonia	Y	N
Polio	Y	N	Tuberculosis	Y	N
Chicken Pox	Y	N	Measles	Y	N
Mumps	Y	N	Rheumatic/Scarlet Fever	Y	N

FEMALES ONLY	Mild	Medium	Severe
Premenstrual tension	☐	☐	☐
Congested breasts	☐	☐	☐
Lumps in breasts	☐	☐	☐
Painful menstruation	☐	☐	☐
Menstrual cramps	☐	☐	☐
Menstrual backache	☐	☐	☐
Excessive flow	☐	☐	☐
Hot Flashes	☐	☐	☐
Irregular Cycle	☐	☐	☐
Menopausal symptoms	☐	☐	☐
Vaginal discharge	☐	☐	☐

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(416) 231-2487

Name: _____ Date: _____

VISUAL PAIN & STIFFNESS RATING SCALE

1) Make a mark (/) along the line to indicate the current level of pain of your main complaint.

No Pain _____ Unbearable Pain

1 .....5.....10

2) Make a mark (/) along the line to indicate the current level of stiffness of your main complaint.

No Stiffness _____ Unbearable Stiffness

1 .....5.....10

PAIN DIAGRAM

On the diagram indicate all areas of;

Pain - xxx
Stiffness - ///
Numbness - 000