



PATIENT APPLICATION FORM

Name: _____ (Age) _____ Gender: M F
 Home Address: _____ Home Phone: () _____
 City: _____ Province: _____, Postal Code: _____ Work Phone: () _____
 Email Address: _____ Cell Phone: () _____
 Birth Date (MM/DD/YY): ____ / ____ / ____ Marital Status: S M D W
 Occupation: _____ Employer Name: _____
 Emergency Contact Name: _____ Phone: () _____
 Family Physician Name: _____ Phone: () _____
 How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _____
 Is this purpose related to an auto accident / work injury? Yes No If so, when: _____
 When did this condition begin? ____ / ____ / ____ Did it begin: Gradual Sudden Progressive over time?
 What activities aggravate your symptoms? _____
 Is there anything, which has relieved your symptoms? Yes No Describe: _____
 Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting
 Does the Pain Radiate into your: ___ Arm ___ Leg ___ Does not radiate Is this condition getting worse? Yes No
 How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with Activity
 Does complaint(s) interfere with: ___ Work ___ Sleep ___ Hobbies ___ Daily Routine Explain: _____
 Have you experienced this condition before? Yes No If so, please explain: _____
 Who have you seen for this? _____ What did they do? _____
 How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? _____ When? _____
 Reason for visits: _____
 How did you respond? _____
 Have you had any imaging (X-rays, MRI or CT) done for your condition? Yes No When? _____
 What were the findings of the imaging: Degeneration Slipped Disc Pinched Nerve Arthritis Bone Spur No Findings?
 Did you know posture determines your health? Yes No
 Are you aware of any of your poor posture habits? Yes No
 Explain: _____

TELL US ABOUT YOUR LIFESTYLE HABITS

Do you exercise? Yes No How often? **1X 2X 3X 4X 5X** per week Other: _____
 What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming Other: _____
 Do you smoke? Yes No How much? _____
 Do you drink alcohol? Yes No How much / week? _____
 Do you drink coffee? Yes No How many cups / day? _____
 Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (Gray's Anatomy, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.

↓ Please Check Below ↓

Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	<input type="checkbox"/> headaches, <input type="checkbox"/> nervousness, <input type="checkbox"/> insomnia, <input type="checkbox"/> head colds, <input type="checkbox"/> high blood pressure, <input type="checkbox"/> migraine headaches, <input type="checkbox"/> nervous breakdowns, <input type="checkbox"/> amnesia, <input type="checkbox"/> chronic tiredness, <input type="checkbox"/> dizziness.
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	<input type="checkbox"/> sinus trouble, <input type="checkbox"/> allergies, <input type="checkbox"/> pain around the eyes, <input type="checkbox"/> earache, <input type="checkbox"/> fainting spells, <input type="checkbox"/> certain cases of blindness, <input type="checkbox"/> crossed eyes, <input type="checkbox"/> deafness.
3C	Cheeks, outer ear, face bones, teeth, tri-facial nerve.	NECK REGION <input type="checkbox"/> neuralgia, <input type="checkbox"/> neuritis, <input type="checkbox"/> acne or pimples, <input type="checkbox"/> eczema.
4C	Nose, lips, mouth, eustachian tube.	
5C	Vocal cords, neck glands, pharynx.	<input type="checkbox"/> hay fever, <input type="checkbox"/> runny nose, <input type="checkbox"/> hearing loss, <input type="checkbox"/> adenoids.
6C	Neck muscles, shoulders, tonsils.	<input type="checkbox"/> laryngitis, <input type="checkbox"/> hoarseness, <input type="checkbox"/> throat conditions such as sore throat or quinsy.
7C	Thyroid gland, bursae in the shoulders, elbows.	<input type="checkbox"/> stiff neck, <input type="checkbox"/> pain in upper arm, <input type="checkbox"/> tonsillitis, <input type="checkbox"/> chronic cough, <input type="checkbox"/> croup.
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	<input type="checkbox"/> bursitis, <input type="checkbox"/> colds, <input type="checkbox"/> thyroid conditions.
2T	Heart, including its valves and covering; coronary arteries.	MID-BACK <input type="checkbox"/> asthma, <input type="checkbox"/> cough, <input type="checkbox"/> difficult breathing or shortness of breath, <input type="checkbox"/> pain in lower arms and hands.
3T	Lungs, bronchial tubes, pleura, chest, breast.	
4T	Gall bladder, common duct.	
5T	Liver, solar plexus, circulation (general).	
6T	Stomach.	
7T	Pancreas, duodenum.	
8T	Spleen.	
9T	Adrenal and supra-renal glands.	
10T	Kidneys.	
11T	Kidneys, ureters.	
12T	Small intestines, lymph circulation.	
1L	Large intestines, inguinal rings.	
2L	Appendix, abdomen, upper leg.	
3L	Sex organs, uterus, bladder, knees.	
4L	Prostate gland, muscles of the lower back, sciatic nerve.	
5L	Lower legs, ankles, feet.	
SACRUM	Hip bones, buttocks.	PELVIS <input type="checkbox"/> sacro-iliac conditions, <input type="checkbox"/> spinal curvatures.
COCCYX	Rectum, anus.	

*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.

PATIENT SIGNATURE _____

DATE _____

PATIENT CONSENT FORM

I do hereby authorize the doctors of **Yonge Finch Chiropractic and Health Centre** to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments, and other chiropractic procedures, including various modes of physical therapy and referral for diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes (1:5Mill), dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I understand the fee structure and accept full responsibility for prompt payment. Being late for the scheduled appointment may result in a shorter treatment. I understand that I am responsible for paying the full appointment fee if I do not give 24 hours notice of change or cancellation.

Visa or MC # _____ EXP _____
(please check card type)

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) of which I seek treatment.

Consent to evaluate and adjust a minor child

I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

PATIENT SIGNATURE _____

DATE _____

DOCTOR SIGNATURE _____

DATE _____

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