Dr.Douglas Cameron
1111 Franklin Blvd., Unit 1B
Cambridge, ON, N1R 8B5

Saginaw Chiropractic Centre

www.saginawchiro.com

519-624-6199

PATIENT INFORMATION

PERSONAL INFORMATION **Date** _____

Name: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____

Date of Birth (D/M/Y): _____ Age: _____ Email:_____

Occupation: _____ Employer: _____

Address: _____

HEALTH COVERAGE
Extended Health Care Co. _____

How did you hear about our office: Friend ☐ Sign ☐ Bell Yellow Pages ☐ Internet ☐

Other: _____

Is this a motor vehicle accident claim or WSIB claim?

1. Recent motor vehicle accident _____ Date of MVA _____
2. Work related injury/accident _____ Date of injury _____

   Social Insurance Number (workplace injuries only) _____

PRIOR CHIROPRACTIC CARE:

Name: _____ Date: _____

X-rays taken: YES NO Date: _____

MEDICAL DOCTOR:

Name: _____ Telephone: _____

Address: _____

Date of Last Appointment: _____ Last Physical: _____

Reason for consulting this office:

€ Prevention/wellness care.
€ Current Problem (describe below):

_____

_____

_____

_____

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Your Name: _____

What are your goals/expectations for your care:

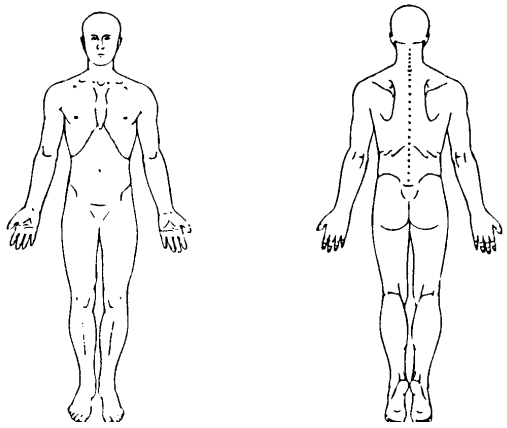
_____

_____

Please indicate affected areas on drawings:

Describe the character of your pain/discomfort:

€ Sharp pain € Dull, achy pain
€ Burning € Tingling
€ Numbness € Weakness
€ Throbbing



Please indicate the pain severity :
(0 = no pain, 10 = worst pain)

1 2 3 4 5 6 7 8 9 10

Is the pain: constant intermittent very infrequent

Since the problem began is your pain:
€ increasing € decreasing € not changing

When did this problem begin: _____

Habits of Lifestyle:
Do you smoke: yes ___ no ____ If so, how much _____, for how long _____.

Do you exercise: yes ____ no ____ Activities _____

Rate your sleep, hours per night: 4-6 6-8 8-12 12+

Do you wake rested? Yes ____ no ____

Rate your appetite: Poor Fair Good

Rate your diet: Poor Fair Good Meals per day _____

Falls and Accidents – list: _____

_____

Surgery and Operations: _____

Surgery recommended but not performed: _____

Please indicate current medications: _____

PERSONAL HEALTH HISTORY - Please circle any that apply: heart disease, diabetes, asthma, high blood pressure, thyroid disease, cancer, arthritis, stroke, aneurysm, psoriasis. Other: _____

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Your Name: _____

FAMILY HEATLH HISTORY - **Please circle any that apply:** : heart disease, diabetes, asthma, high blood pressure, thyroid disease, cancer, arthritis, stroke, aneurysm, psoriasis. Other: _____

Please check all symptoms or areas where you have problems:

Headaches	Loss of taste/smell	Chest pain	Low back pain
Dizziness	Buzzing/Ringing in Ears	Menstrual pain	Hip Pain
Eye/vision problems	Fainting	Lungs	Leg pain/cramps
Concentration loss	Sinus	Heart	Poor circulation
Depression	Neck pain/stiffness	Stomach	Hot flashes
Nervousness	Upper back	Bladder/urination	Cold sweats
Loss of energy	Mid back	Constipation	Diarrhea
			Fever

I hereby authorize the Doctor to examine me understanding that such examinations can periodically lead to aggravation of symptoms. Further, I understand that information provided on this form and in the consultation/examination are part of my health record and are confidential. This information will not be released without my expressed consent. Name and address information may be used to contact me regarding appointments and billings.

Patient Name: _____

Patient Signature: _____ Date: _____