Dr. Maria Davidovic, BA Spec. (Hons.), D.C.
Doctor of Chiropractic
1246 Yonge St. Suite 303
Toronto, ON M4T 1W5
416.906.0767

INTAKE FORM

Today's date: mm/dd/yy / /				
PATIENT INFORMATION				
Patient's last name:		First name:	❑ Mr. ❑ Mrs.	❑ Ms. ❑ Miss. ❑ Dr.
Sex: ❑ M ❑ F	Age:	Date of Birth (MM/DD/YYYY): / /		
Address:				
City:		Province:	Postal Code:	
Please indicate which number you prefer to be reached at/left a voicemail by checking Y☑ OR N☑				
(**Home #**): ( ) - ❑Y ❑N Leave a voicemail: ❑Y ❑N		(**Cell #**): ( ) - ❑Y ❑N Leave a voicemail: ❑Y ❑N	(**Work #**): ( ) - ❑Y ❑N Leave a voicemail: ❑Y ❑N	
Email Address:		Occupation:		
Emergency Contact Person:		Relationship:	Phone:	
Referred to clinic by (please check one box):		❑ Dr.	❑ Insurance Plan:	
❑ Family	❑ Friend	❑ Close to home/work	❑ Web site	❑ Signage
❑ Other:				
Other family members seen here:				
Do you want to be included in future emails/newsletters? ❑Y ❑N Email:				

PREVIOUS CHIROPRACTIC EXPERIENCE			
Previous Chiropractor's name:	Previous Chiropractor's phone:	Date of last Chiropractor's visit:	Reason for visit:
MEDICAL			
Medical Doctor's name:		Medical Doctor's telephone:	
I consent to allow my Chiropractor to contact my Medical Doctor about my health care			
Patient/Guardian signature		*Date*	
Witness signature		*Date*	

Please note that all accounts are the responsibility of the patient. Your Extended Health Care Insurance Plan may provide coverage for Chiropractic services. We will issue a receipt for each payment for this purpose.

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COMPLAINT HISTORY

What is your complaint?

When did you first notice this complaint?

What caused this complaint?

Describe your current pain/discomfort:

How often does your pain occur?

Is your condition getting worse? ❑ Y ❑ N

Rate your pain/discomfort **(PLEASE CIRCLE)** : (None) 0 -1 -2 -3 -4 -5 -6 -7 -8 -9 -10 (Worst pain ever)

What activities aggravate your complaint?

What activities relieve your complaint?

Does your pain radiate or shoot anywhere else? If so, where?

Have you received any treatment for this complaint? If so, what kind of treatment?

Have you ever been treated for the same/similar complaint in the past? If so, when?

HEALTH HISTORY

Do you have any ongoing medical problems or disabilities?

Please list dates and descriptions of any previous accidents or surgeries you have had:

Please list any childhood illnesses/surgeries:

Please list any medications you are currently taking and what you are taking them for:

How many hours do you sleep per night?	How's your quality of sleep: Good/fair/poor
How many days do you exercise per week?	How would you rate your diet? Good/fair/poor
How much water do you drink per day?	How much caffeine do you drink per day?

Do you drink alcohol? ❑ Y ❑ N If so, how many drinks per day? /d Or Per week? /w

Are you a smoker? ❑ Y ❑ N If yes, how many packs per day? For how many years?

Please check if you *have* or *have had* any of the following conditions:

❑ Cancer	❑ Heart Disease	❑ Stroke	❑ Diabetes
❑ Arthritis	❑ High Cholesterol	❑ Hypertension	❑ Low blood pressure
❑ Hepatitis	❑ HIV/AIDS	❑ Other	

FAMILY HISTORY

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed **Children:**

Please check if any of your family members *has* or ever *had* any of the following conditions. If so, *how are they related to you*?

❑ Cancer	❑ Heart Disease	❑ Stroke	❑ Diabetes
❑ Arthritis	❑ High Cholesterol	❑ Hypertension	❑ Other

The above information is true to the best of my knowledge. I agree and understand that I am responsible for all charges relating to my visit. I am responsible for the full visit fee if I do not provide 24-hour notice for cancellation/rescheduling.

Patient (or Guardian signature) *Date*

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HEALTH STATUS SURVEY

Name:___________________________________ Date:____________________ File#:___________________

Please ☒ the box for any conditions or symptoms **PRESENTLY** causing you problems. Please check ☑ the box for those conditions or symptoms that you have had **IN THE PAST.**

GENERAL SYMPTOMS		RESPIRATORY	SKIN
❑ Loss of consciousness ❑ Blackouts ❑ Headache ❑ Fever ❑ Excess sweating ❑ Night sweats	❑ Loss of weight ❑ Night Pain ❑ Generalized pain ❑ Nervousness ❑ Convulsions ❑ Loss of sleep	❑ Asthma ❑ Chronic cough ❑ Spitting up phlegm ❑ Spitting up blood ❑ Difficulty breathing	❑ Rashes/itching ❑ Bruise easy ❑ Dryness ❑ Boils ❑ Hives (allergies)
NEUROLOGIC	**CARDIOVASCULAR**	**GASTROINTESTINAL**	**MUSCLES & JOINTS**
❑ Dizziness ❑ Fainting ❑ Problem speaking ❑ Problem swallowing ❑ Blurred vision ❑ Double vision ❑ Nausea ❑ Clumsiness ❑ Numbness or tingling	❑ Bleeding disorder ❑ High blood pressure ❑ Chest pain ❑ Stroke ❑ Hardening of arteries ❑ Varicose veins ❑ Swelling of ankles ❑ Poor circulation ❑ Heart/blood disease ❑ Angina	❑ Poor appetite ❑ Indigestion ❑ Excess hunger ❑ Belching or gas ❑ Vomiting ❑ Pain over stomach ❑ Constipation ❑ Diarrhea ❑ Hemorrhoids (piles) ❑ Jaundice ❑ Gall bladder trouble ❑ Intestinal worms ❑ Ulcer ❑ Diabetes	❑ Sore/stiff neck ❑ Mid back ache ❑ Low back ache ❑ Painful tailbone ❑ Shoulder pain ❑ Arm/forearm pain ❑ Elbow pain ❑ Wrist/hand pain ❑ Hip pain ❑ Knee pain ❑ Ankle/foot trouble ❑ Arthritis ❑ Loss of strength
EYES/EARS/NOSE/THROAT	**GENITOURINARY**	**GENITOURINARY FOR WOMEN**	
❑ Failing vision ❑ Eye pain ❑ Failing hearing ❑ Earache ❑ Ring/buzz in ears ❑ Frequent colds ❑ Sinus infection ❑ Enlarged thyroid ❑ Enlarged glands	❑ Trouble urinating ❑ Blood in urine ❑ Kidney infection ❑ Bedwetting ❑ Prostate trouble	❑ Painful menstruation ❑ Excessive flow ❑ Hot flashes ❑ Irregular/absent cycle ❑ Cramping/backache ❑ Vaginal discharge ❑ Swollen breasts ❑ Lump in breasts	**Currently on birth control pills/patch?** ❑ Yes ❑ No **Previously on birth control /pills/patch?** ❑ Yes ❑ No **# of pregnancies:** __________ **# of children:** __________

Have you ever had any fractures? ❑ Yes ❑ No
If yes, where?

Have you ever been hospitalized? ❑ Yes ❑ No
Why/When?

Have you ever been in a car accident? ❑ Yes ❑ No
If yes, when?

Are you currently a smoker? ❑ Yes ❑ No # packs/week:_______
Did you smoke previously? ❑ Yes ❑ No # packs/week:_______

Have you ever been diagnosed with:
With Cancer? ❑ Yes ❑ No
With HIV/AIDS? ❑ Yes ❑ No
With Hepatitis A/B/C? ❑ Yes ❑ No

Medication/Supplements list:

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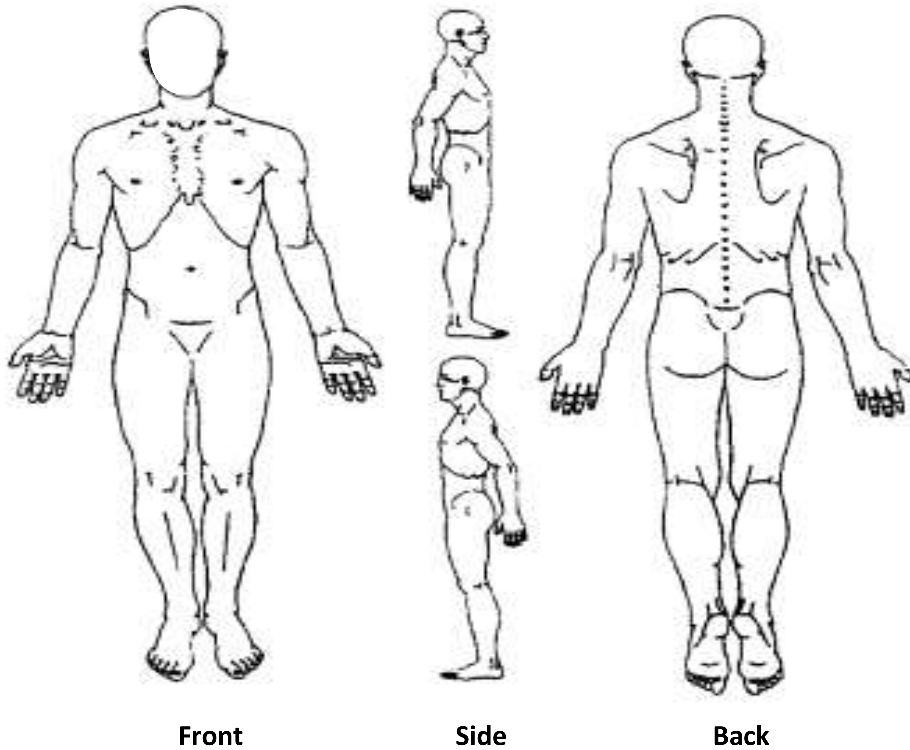
Symptom Diagram

Pt Name: ____ Date:_______________

In the diagram provided below, please mark the area(s) on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include ALL areas. Use the symbols provided below. Please draw in the face on the diagram as well.

Symbols:	Numbness	======	Pins and Needles ºººººº
	Burning	xxxxxxxxx	Stabbing & Sharp ~~~~
	Dull & Aching	△△△△△△	Stiff & Tight 222222



What are your Chiropractic goals?

❑ I would like treatment for my existing pain(s) only
❑ Once better, I would like treatment for another area of concern or strategies to prevent injury/pain reoccurrence
❑ I would like regular **Maintenance Care** to keep my body in check from time to time

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