ADVANCED HEALTHCARE
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CONFIDENTIAL NEW PATIENT INFORMATION

Welcome to our office! Please complete all questions…

PERSONAL HISTORY: **Today's Date: (D) ___ / (M) ______ / (Y) _____**

Name: ___________________________ Other:_______ Address: ______________________________________

City: ________________ Province: ____ Postal Code: ________ **Health Card #:** __________________ **Ver #:**___

Home Tel #: ( ) _____________________ Birth Date: (D) ___ / (M) ______ / (Y) _____ Age: ____ Sex: ______

Cell Tel #: ( ) ____________ Email: _________________________ Last MD physical exam date: __________

Do you have Extended Health Coverage? ☐ Not Sure ☐ No ☐ If yes, with whom? ________________________

Business/Employer: ___________________________________ Type of Work: __________________________

Business Tel #: ( ) ________________________ Marital Status: (Circle One) M S W D CL (Common-Law)

Children's names and ages:

1. _________________________________ Age _____ 3. _________________________________ Age _____

2. _________________________________ Age _____ 4. _________________________________ Age _____

Who can we thank for referring you to us: ____________________________ Tel #: ( ) ____________

CURRENT HEALTH CONDITION(S): Your Present: Height _____ Weight ______ Shoe Size _____

List your **3 top** current health complaints in order of priority… **Other complaints, please advise Dr. Pisarek:**

1. ________________________________ When and how did it start? ___________________________________
2. ________________________________ When and how did it start? ___________________________________
3. ________________________________ When and how did it start? ___________________________________

Have these conditions occurred before? ☐ No ☐ Yes. Please explain: ______________________________

Is it getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes & Goes ☐ Other: _______________________________

Pain character: ☐ Sharp ☐ Dull ☐ Tight / Stiff ☐ Achy ☐ Burning ☐ Throbbing ☐ Numb ☐ Pins/Needles

Rate your overall pain level on a scale of 1 to 10 (10 being the highest): _____. Please describe how it feels when this problem is at its worst: ____

What aggravates your condition(s)? ☐ Sitting ☐ Standing ☐ Lying down ☐ Bending ☐ Lifting ☐ Walking ☐ Running ☐ Jumping ☐ Cold ☐ Heat ☐ Rain ☐ Dampness ☐ Other ____________________________

What relieves your condition(s)? ☐ Chiropractic adjustments ☐ Bed Rest ☐ Sitting ☐ Standing ☐ Walking ☐ Stretching / Exercise ☐ Ice ☐ Heat ☐ Massage ☐ Medication ☐ Rubs ☐ Other___________________

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: ____ /10.

Medications, Vitamins, Herbal Remedies you now take: ____

Have you had X-rays taken in the past six months? ☐ No ☐ Yes, where? ____________________________

PAST HEALTH HISTORY: (Please check, circle, and/or describe)

Major Surgery / Operations: ☐ Cancer ☐ Stroke ☐ Heart Attack ☐ Brain ☐ Gall Bladder ☐ Hernia ☐ Fractures ☐ Joint Sprains / Strains ☐ Appendectomy ☐ Tonsillectomy ☐ Other: ___________________________

Auto Accidents, Slips, Falls, Trips: ____

Hospitalizations (other than above): ____

Previous Chiropractic Care: ☐ None ☐ If yes, when was your last chiropractic adjustment: _______________

Chiropractor's Name(s): ____

Chiropractor's Address: ____

Do you presently or in the past smoke(d): Tobacco/Cannabis/Vape products ☐ Yes ☐ No; used THC/CBD ☐ Yes ☐ No

(PLEASE TURN OVER)

Below is a list of problems that may seem unrelated to the purpose of your appointment today. However, these questions must be answered carefully, as these problems may affect your overall course of chiropractic care…

CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE PAST 6 MONTHS, OR FOR A SIGNIFICANT AMOUNT OF TIME IN YOUR LIFE…

MUSCULO-SKELETAL:

☐ Neck Pain ☐ Shoulder Pain
☐ Arm Pain ☐ Elbow Pain
☐ Wrist Pain ☐ Hand Pain
☐ Low Back Pain ☐ Leg Pain
☐ Hip - Knee - Ankle - Foot Pain (Circle)
☐ Jaw (TMJ) Pain ☐ Chewing Problems
☐ Arthritis? Where: ________________

NERVOUS SYSTEM:

☐ Headaches ☐ Concussion
☐ Numbness ☐ Paralysis
☐ Vertigo ☐ BPPV
☐ Dizziness ☐ Tinnitus (Ear Noise)
☐ Fainting ☐ Meniere's Disease
☐ Confusion ☐ Memory Problems
☐ Convulsions ☐ Epilepsy ☐ Anger Prob.
☐ Stress ☐ PTSD ☐ Anxiety
☐ Depression ☐ Crying Outbursts
☐ Cold - Numb - Tingling Extremities

GENERAL:

☐ Fatigue ☐ Low Energy
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Gas ☐ Bloating After Meals
☐ Poor Diet / Eating Habits
☐ Problems with: ☐ Getting Up ☐ Sitting ☐ Standing ☐ Walking
☐ Running ☐ Jumping ☐ Bending ☐ Twisting
☐ Diabetes? Please describe: ____
☐ Cancer? Please describe: ____

GENITO-URINARY:

☐ Bladder Trouble
☐ Painful and/or ☐ Excessive Urination
☐ Discoloured Urine

CARDIO-VASCULAR:

☐ Stroke History ☐ Heart Attack
☐ Chest Pain ☐ Heart Problems
☐ Irregular Heartbeat ☐ Snoring
☐ Blood Pressure ☐ Low ☐ High
☐ Asthma ☐ Shortness of Breath
☐ Lung Problems ☐ Congestion
☐ I use a CPAP Machine ☐ Yes ☐ No
☐ Varicose Veins ☐ Ankle Swelling

EYES-EARS-NOSE-THROAT:

☐ Vision Problems ☐ I Wear Glasses
☐ Eye Cataracts ☐ Dental Problems
☐ Sore Throat ☐ Coughing ☐ I Smoke
☐ Earaches ☐ Hearing Difficulty
☐ I Wear Hearing Aids ☐ Yes ☐ No
☐ Stuffy Nose ☐ Sinus Problems

DO YOU HAVE A REGULAR EXERCISE PROGRAM?

☐ No ☐ If yes, describe: _____________
____
____

FEMALES ONLY:

When was your last period?
(D) ___ (M) ______ (Y) 20__
Are You Pregnant?
☐ Yes ☐ No ☐ Not Sure

GASTRO-INTESTINAL:

☐ Poor or ☐ Excessive Appetite
☐ Excessive Thirst ☐ Heartburn
☐ Frequent Nausea ☐ Indigestion
☐ Vomiting ☐ With Blood
☐ Diarrhea ☐ Colitis
☐ Constipation ☐ Black / Bloody Stool
☐ Abdominal Cramps ☐ Hunger Prob.
☐ Liver Problems ☐ Hemorrhoids
☐ Gall Bladder Problems
☐ Weight Trouble ☐ Gain ☐ Loss
☐ I Consume Alcohol ☐ Yes ☐ No

FEMALE / MALE:

☐ Menstrual Irregularity
☐ Menstrual Cramping
☐ Vaginal Pain ☐ Vaginal Infections
☐ Breast Pain ☐ Breast Lumps
☐ Frequent Urination
☐ Sexual Dysfunction
☐ Prostate Problems

LIFESTYLE STRESS LEVEL:

☐ High ☐ Moderate ☐ Minimal

HEREDITARY (GENETIC) DISEASES: ☐ No ☐ Not Sure ☐ Yes, please describe: ____________________________
____

Why Chiropractic? People visit Chiropractors for a variety of reasons. Some go for symptomatic relief of pain/discomfort (Relief Care). Others are interested in having the cause of their problem(s) as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies improved to the highest state of health possible with Chiropractic care (Prevention Care). These are the three phases of care. If accepted, Dr. Pisarek will weigh your needs and desires when recommending your program and schedule of care. His prepared recommendations are an incorporation of all three (3) phases and will be discussed privately with you during your 'results' visit.

Please check the type of care desired so that Dr. Pisarek may be guided by your wishes whenever possible:

☐ **Preventative Care** ☐ **Corrective Care** ☐ **Relief Care**

☐ **Check here if you want Dr. Pisarek to select the best type of care appropriate for your condition(s).**

PLEASE READ CAREFULLY: I acknowledge and agree that health and accident insurance policies constitute an agreement between an insurance carrier and myself. The staff at Dr. Pisarek's office will make every effort to prepare any necessary reports and forms to assist me in facilitating reimbursement from my insurance company. Any sum authorized to be paid directly to Dr. Pisarek will be applied as a credit to my account upon receipt. Additionally, I fully comprehend and agree that all services provided to me are billed directly to me, and I am personally accountable for settling my account with Dr. Pisarek. Lastly, I grant Advanced Healthcare, Dr. Pisarek and Staff permission to communicate with me electronically via telephone, fax, or the internet when necessary.

PATIENT SIGNATURE: ________________________________ **Dated: (D)** ______ **(M)** _______ **(Y)** _______