DR. ATOOSA
CHIROPRACTOR
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P: (416) 222-7775
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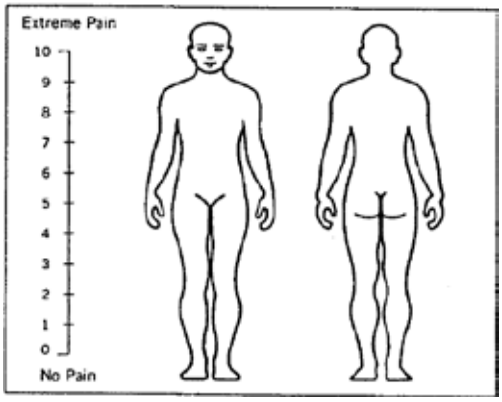
St. Gabriel Medical Centre
650 Sheppard Avenue East
North York, ON M2K 3E4

Patient information (please print)

Full Name: _____ Date of Birth: (mm/dd/yyyy)_____ Gender: M F

Occupation: _____

If you are in pain, mark the exact location on the diagram and indicate the amount of pain that you are in by circling the representative number on the scale.




Describe the type of pain:

- ❑ Sharp
- ❑ Dull/achy
- ❑ Spasm
- ❑ Numb/pins & needles/tingly
- ❑ Other: _____

NOTES:

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## Confidential Patient Intake Form

**CURRENT HEALTH OVERVIEW** *cont'd*

| | | |
|---|---|---|
| Describe how this condition developed (what caused it? How did it start?) | | |
| What makes this condition … | WORSE | BETTER |
| When was the first time that you were aware of this condition? | | |
| Have you ever had this problem before? | ☐ YES<br>☐ NO | If YES, when? |
| What is the frequency of this problem?<br><br>What is the duration of this problem? | | |
| Does the pain travel from the source of pain? | ☐ YES<br>☐ NO | If YES, where does it travel to/from? |
| Have you ever received treatment for this condition? | ☐ YES<br>☐ NO | If YES,<br>By who<br>When<br>Results |
| Has this condition been getting … | ☐ BETTER<br>☐ WORSE<br>☐ SAME | |
| Does this cause you to be restricted in daily activities? | ☐ YES<br>☐ | If YES, describe which activities |

*Continued…*

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Have you had any trauma in the past?_____

Have you been hospitalized for any other reason than listed above? _____

Does your family have a history of any of the following?

| | | | |
|---|---|---|---|
| | Heart disease | | Back pain |
| | Diabetes | | Osteoporosis |
| | Arthritis | | Cancer<br>Describe type: |
| | Other: | | |

| | | | |
|---|---|---|---|
| Have you had any x-rays/mri/ct scans taken? | ❑ YES<br>❑ NO | If YES, | |
| | | Of what | |
| | | Results | |

| | | |
|---|---|---|
| Does this affect your work? | ❑ YES<br>❑ NO | If YES, how? |
| Are you taking any of the following types of medications? | ❑ Nerve pills<br>❑ Pain killers/muscle relaxants/anti-inflammatories<br>❑ Blood pressure medicine<br>❑ Insulin<br>❑ Other: | |
| In general, would you say your overall health right now is … | ❑ Excellent<br>❑ Very Good<br>❑ Good<br>❑ Fair<br>❑ Poor | |
| Do you work out/exercise? | ❑ YES<br>❑ NO | If YES, describe activities |
| Do you suffer from any condition other than that which you are now consulting us? | ❑ YES<br>❑ NO | If YES, describe |