Dr. Daniel Javitz,B.Sc(Hons),D.C, R.Ac
North York_Thornhill_Vaughan Areas
(416) 671 - 2275 drjavitz.com

CHIRO–NEW PATIENT INTAKE FORM
(PLEASE PRINT AND FILL OUT)

FOR OFFICE USE ONLY
Date of First Visit: _____

PERSONAL INFORMATION/HISTORY — Information is Strictly Confidential — Please Answer Everything

Full Name: _____ Legal Guardian Name (if applicable):_____
Address: _____ City: _____ Province:_____ Postal Code: _____
Phone#s: Home(___)_____ Mobile/Cell:(___)_____ Business/Work:(___)_____Ext: _
Birthdate: ___/___/___(D/M/Y) Age: ___ Sex: ❑M ❑F **Occupation/Work?:** _____
Marital Status (Check one): ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated ❑Other ‖ Children#:__
Family Doctor Name: _____ **Family Doctor phone number:** (___)_____
Emergency Contact Name: _____→Relationship to You: _____→Phone #: (___)_____
Email Address: _____ **Extended Health Insurance Company Name:**_____
How did you hear about the clinic? ❑Referral who?_____ ❑Signs where?_____ ❑Internet ❑Other_____
FOR CLINIC DIRECT BILLING: Insurance Policy#:_____ **Insurance Member ID#:**_____
Secondary Insurance Available?(i.e.Spouse's insurance?):❑YES ❑NO. **If YES, Please fill in below**
Spouse's Name → First: _____ Middle:_____ Last:_____ Sex: ❑M ❑F
Spouse's Birthdate: ____/____/____(D/M/Y) Extended Insurance Company Name: _____
Spouse's Insurance Policy #:_____ Insurance Member ID #:_____

FOR THE BILLING INFORMATION BOXED BELOW, PLEASE FILL OUT ONLY IF IT APPLIES TO YOUR INJURY:

Type of injury: Is this a Workplace Safety & Insurance Board injury(WSIB)? ❑Yes ❑No **(If No, you do not need to fill the following)**
WSIB claim #? _____ Date of Accident: __/__/__(D/M/Y) Employer's name: _____
Employer's address and telephone:_____

Type of injury: Related to a motor vehicle accident (MVA) case? ❑Yes ❑No **(If No, you do not need to fill the following)**
Date of Accident: __/__/__(D/M/Y) Insurer's name: _____Policy or claim #: _____
Insurer's address and telephone: _____

CURRENT HEALTH CONDITION

Reason for your visit today: → ❑ Wellness/Preventative Care OR ❑ Relief Care/Corrective Care

List your complaints (worst problem at the top #1)

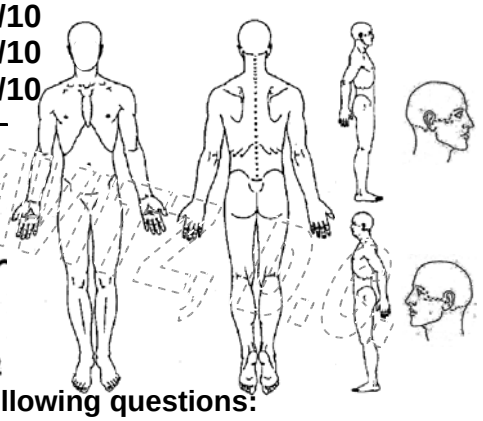
Use this Intensity Line as a Guide →

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate — Severe

1. _____ When did it start? _____ Intensity Rating?___/10
2. _____ When did it start? _____ Intensity Rating?___/10
3. _____ When did it start? _____ Intensity Rating?___/10

USING THESE SYMBOLS, MARK THE TYPE OF DISCOMFORT ON THE BODY PICTURES ON THE RIGHT SIDE →

Numbness ≡≡≡≡≡≡≡ Pins and Needles ooooo
Burning xxxxxx Stabbing & Sharp ~~~~
Dull & Aching ΔΔΔΔΔΔ Stiff & Tight 2222



Regarding Your First Major (#1) Complaint listed above, please answer the following questions:
How did the condition/pain begin? _____ Has this condition happened before? ❑Yes ❑No
Does the condition/pain stay local ❑Yes ❑No, **OR** Does the condition/pain move to arm/leg ❑Yes ❑No
Other Professionals seen for this condition? ❑ Medical DR ❑ Chiropractor ❑ Physio ❑ Other: _____
When was your last visit? _____ What was the recommended treatment?_____
Have you had X-rays or other imaging in the last 12 months? ❑Yes ❑No (What Region of body?):_____
Medications you now are taking: ❑Pain Killers/Muscle Relaxers ❑Antibiotics ❑Cholesterol ❑Diabetic ❑Blood Pressure ❑Blood Thinners ❑Anti-inflammatory ❑Antidepressants ❑Other:_____

Patient/Legal Guardian's Signature for both page #s 1 & 2 (Sign in the clinic) **X**_____
DR/Witness/Assistant's Signature **X**_____ DR/Witness/Assistant's name_____

PAST AND FAMILY HEALTH HISTORY (PLEASE CHECK OR DESCRIBE WHERE INDICATED)

Try to indicate all previous slips, falls, accidents, surgeries and/or childhood traumas: _____

_____

FAMILY HEALTH	Diabetes	Heart	Cholesterol	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑	❑
Brother, # of __	❑	❑	❑	❑	❑	❑
Sister, # of __	❑	❑	❑	❑	❑	❑

List all Your Allergies (Foods, Medications, Seasonal, Other)

_____

Do you take Nutritional Supplements? ❑ Yes ❑ No
If Yes, list →

Below is a health history form with a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions **MUST** be answered as these problems can affect your chiropractic care.

PLEASE CHECK-MARK '/' FOR ANY OF THE SYMPTOMS YOU HAVE NOW AND 'X' IF HAD IN THE PAST

- ☐ Anemia
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Stroke
- ☐ Atherosclerosis
- ☐ High Cholesterol
- ☐ Alcoholism
- ☐ H.I.V.
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Emphysema
- ☐ Cold sores
- ☐ Hepatitis A B or C
- ☐ Venereal Disease
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Diptheria
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Scarlet Fever
- ☐ Pneumonia
- ☐ Ulcers
- ☐ Mumps
- ☐ Eczema
- ☐ Measles

Psychosocial: Have any of the following occurred recently?

- ☐ Depression
- ☐ Death
- ☐ Divorce
- ☐ Increased work stress
- ☐ Change of job status
- ☐ Chronic Fatigue
- ☐ Drugs / Alcohol increase
- ☐ Sleep Disturbances
- ☐ Economic Stress / Anxiety
- ☐ Family Problems
- ☐ Mental Disorders

Musculo-Skeletal

- ☐ Headaches
- ☐ Neck pain
- ☐ Upper / Mid back pain
- ☐ Low back pain
- ☐ Shoulder pain
- ☐ Arm / Leg pain (←Circle region)
- ☐ Wrist / Elbow pain(←Circle)
- ☐ Hip / Knee pain(←Circle)
- ☐ Joint pain / Stiffness
- ☐ Ankle / Foot trouble
- ☐ Walking problems
- ☐ Difficult chewing / Clicking jaw
- ☐ General stiffness

Nervous System

- ☐ Numbness
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Problem Speaking/Swallowing
- ☐ Blurred/Double Vision
- ☐ Clumsiness

Cardiovascular

- ☐ Chest pain
- ☐ Short breath
- ☐ Blood pressure problems
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Lung problems
- ☐ Ankle swelling

Male / Female

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping/Back Pain
- ☐ Breast pain / Lumps
- ☐ Prostate / Sexual dysfunction
- ☐ Painful/Excessive urination
- ☐ Discolored urine
- ☐ Are you pregnant? ☐ Yes ☐ No

Gastro-Intestinal

- ☐ Gas / Bloating after meals
- ☐ Heartburn
- ☐ Poor / Excessive appetite
- ☐ Excessive thirst
- ☐ Nausea / Vomiting
- ☐ Diarrhea / Constipation
- ☐ Black / Bloody stool
- ☐ Colitis
- ☐ Weight trouble
- ☐ Gallbladder trouble
- ☐ Kidney Stones

Eyes, Ears, Nose, Throat

- ☐ Vision problems
- ☐ Frequent sore throats
- ☐ Ear aches
- ☐ Hearing difficulty

Lifestyle

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Satisfied ☐ Unsatisfied

Coffee / Tea

- ☐ 1-2 Daily ☐ 3-4 Daily ☐ More

Alcohol

- ☐ 1-2 Daily ☐ 3-4 Daily ☐ More

Cigarettes

- ☐ 1-2 Daily ☐ 3-4 Daily ☐ More

Sleep Position

☐ Side ☐ Back ☐ Stomach

Do you have a regular exercise program?

☐ Yes, Describe: _____
_____
_____

☐ No

Lifestyle Stress Levels

☐ High ☐ Moderate ☐ Very little

dr. javitz
chiropractic

Form L

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke, but rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustment.

I intend this consent to apply to all my present and future chiropractic care.

Dated this ____ day of _____ , 20___

_____ _____

Patient Signature (Legal Guardian) Witness Signature

Name: _____ Witness Name: _____

(Please Print) (Please Print)

(ENGLISH)