Dr. SARAH RACICOT, BScKin, DC, RTP
CHIROPRACTOR, ACUPUNCTURIST, TRIGENICS PROVIDER

PATIENT INFORMATION

Name: _____ Sex: M / F Age: _____ Date of Birth (d/m/y): ____/_____/_____

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone No.: (____)_____-_____ Work Phone No.: (____)_____-_____ Email: _____

Occupation: _____ Referred to our office by: _____

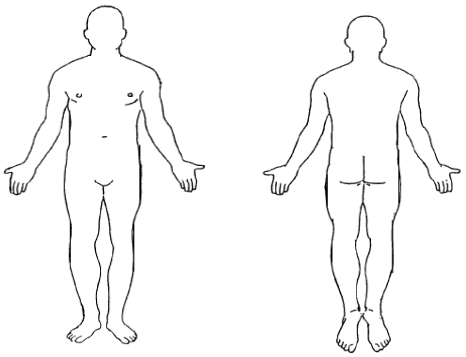
REASON FOR YOUR VISIT

Reason for today's visit: ☐ Emergency ☐ New Injury
☐ Old Injury ☐ Wellness Visit

Injury the result of: ☐ Auto Accident ☐ Work
☐ Sport/Leisure Activities ☐ Slip/Fall ☐ Gradual Onset
☐ Just Came On ☐ Other _____

Date of accident (d/m/y): _____/_____/_____

Date symptoms first appeared (d/m/y): _____/_____/_____



Please circle <u>all</u> affected areas

Are the symptoms: ☐ Improving ☐ Getting worse ☐ About the same ☐ Come & go ☐ Constant

Type of pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins/Needles ☐ Numb ☐ Burning ☐ Other _____

Aggravating activities: ☐ Stand ☐ Walk ☐ Sit ☐ Lying ☐ Bend ☐Lifting ☐ Twist ☐ Cough ☐ Strain

Relieving activities: ☐ Inactivity/Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication ☐ Other _____

Severity of pain: (Circle) **No Pain 0 1 2 3 4 5 6 7 8 9 10 Excruciating Pain**

MEDICATION YOU ARE TAKING	CONDITION BEING TREATED

SURGICAL PROCEDURES	DATE (d/m/y)	CONDITION TREATED

EMERGENCY CONTACT PERSON

Name: _____ Home Phone: (____)_____-_____ Work Phone: (____)_____-_____

Family Physician: _____ Phone No.: (_____) _____-_____

SYSTEMS REVIEW

Please indicate if you've ever had any of the following:

MUSCULOSKELETAL:
☐ Joint stiffness/pain
☐ Muscle cramps
☐ Muscle weakness
☐ Generalised stiffness
☐ Neck pain
☐ Mid back pain
☐ Low back pain
☐ Arm/Hand pain
☐ Leg/Foot pain
☐ Extremity numbness/tingling
☐ Difficulty chewing/Jaw pain
☐ Fracture/Dislocation
☐ Rheumatoid Arthritis

NERVOUS SYSTEM:
☐ Paralysis
☐ Extremity numbness/tingling
☐ Headaches/Migraines
☐ Dizziness
☐ Fainting
☐ Convulsions
☐ Epileptic seizures
☐ Confusion
☐ Head trauma
☐ Stroke
☐ Other:_____

GASTROINTESTINAL:
☐ Nausea/Vomiting
☐ Vomiting/Coughing blood
☐ Ulcer
☐ Indigestion/Heartburn
☐ Abdominal pain/swelling
☐ Stool changes (black/bloody)
☐ Diarrhea/Constipation
☐ Hernia
☐ Gallbladder problems
☐ Liver disease
☐ Pancreatitis
☐ Frequent thirst
☐ Other:_____

URINARY SYSTEM:
☐ Frequent urination
☐ Pain on urination
☐ Change in urine colour
☐ Difficulty start/stop urinating
☐ Pelvic pain
☐ Urinary tract infections
☐ Kidney disease/stones
☐ Flank pain
☐ Other: _____

CARDIOVASCULAR/ RESPIRATORY SYSTEM:
☐ Difficulty breathing
☐ Blood pressure problems
☐ Irregular heartbeat
☐ Heart problems
☐ Lung problems
☐ Ankle swelling
☐ Cold extremities
☐ Cough
☐ Asthma
☐ Blood in sputum
☐ Chest pain
☐ Shortness of breath
☐ Rheumatic fever
☐ Sudden calf pain
☐ Other: _____

EYE/EAR/NOSE/THROAT:
☐ Difficulty swallowing
☐ Vision problems
☐ Dental problems
☐ Difficulty hearing
☐ Ringing in ears
☐ Ear pain
☐ Nosebleeds
☐ Sinusitis
☐ Other:_____

MEN ONLY:
☐ Sexual dysfunction
☐ Prostate swelling
☐ Testicular pain
☐ Other:_____

WOMEN ONLY:
☐ Menstrual irregularity
☐ Breast pain/lumps
☐ Hysterectomy (date:_____)
☐ Menopause (onset:_____)
☐ Hormone Replacement Therapy
☐ Number of children _____
☐ Frequent missed periods
☐ Other: _____

ENDOCRINE SYSTEM:
☐ Thyroid problems
☐ Diabetes (Type 1/ Type2)
☐ Neck surgery/Irradiation
☐ Skin dryness/wetness
☐ Other: _____

GENERAL HEALTH:
☐ Allergies
☐ Anaemia
☐ Bleeding/Bruising
☐ Height change
☐ Weight change
☐ Fever/Chills
☐ Sweats
☐ Night pain
☐ Malaise/Fatigue
☐ Other:_____

LIFESTYLE:
☐ Vegetarian Diet
☐ Alcohol intake per week ____
☐ Coffee/Tea/Caffeine per day____
☐ Cigarettes per day ____
☐ Exercise minutes per week_____

FAMILY HISTORY:
☐ Cancer
☐ Stroke
☐ Heart problems
☐ Diabetes
☐ Other:_____

Dr. Sarah Racicot, BScKin, DC 560 Bryne Drive, 1A Barrie, Ontario L4N 9P6 (705) 733-2033