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: _____ Pronoun: _____ 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 #: ( )** _____

YOUR CURRENT HEALTH CONDITION(S): Height _____ **Weight** _____ **Shoe Size** _____ **(Reg - W - N)**

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 ☐ Nervous ☐ PTSD ☐ Anxiety
☐ Depression ☐ Crying / Yelling Outbursts
☐ Extremities: ☐ Cold ☐ Numb ☐ Tingling

GENERAL:
☐ Fatigue ☐ Energy: ☐ Low ☐ High
☐ Allergies?_____
☐ Loss of Sleep ☐ Nightmares
☐ Fever ☐ Gas ☐ Bloating After Meals
☐ Passing Excessive Gas
☐ Poor Diet ☐ Bad Eating Habits
☐ Problems with: ☐ Getting Up ☐ Sitting ☐ Standing ☐ Walking
☐ Running ☐ Jumping ☐ Bending ☐ Twisting ☐ Squatting

GENITO-URINARY:
☐ Bladder Trouble
☐ Urination: ☐ Painful &/or ☐ Excessive
☐ Discoloured Urine ☐ Bloody ☐ Cloudy

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: _____
_____
_____

GASTRO-INTESTINAL:
☐ Poor or ☐ Excessive Appetite
☐ Eating Disorder? ☐ Excessive Thirst
☐ Frequent Nausea ☐ Indigestion
☐ Vomiting ☐ Vomit with Blood
☐ Diarrhea ☐ Colitis ☐ Heartburn
☐ Constipation ☐ Stool: Bloody / Black
☐ Abdominal Cramps ☐ Hunger Prob.
☐ Liver Problems ☐ Hemorrhoids
☐ Gall Bladder Problems
☐ Weight Problem: ☐ Gain ☐ Loss
☐ I Consume Alcohol: ☐ Yes ☐ No

FEMALES ONLY:
When was your last period?
(D) ___ (M) _____ (Y) 20 ___.
Are You Pregnant?
☐ Yes ☐ No ☐ Not Sure

FEMALE / MALE PROBLEMS:
☐ Fibromyalgia Disorder
☐ Menstrual Irregularity / ☐ Cramping
☐ Vaginal Pain ☐ Vaginal Infections
☐ Breast Pain ☐ Breast Lumps
☐ Frequent Urination
☐ Sexual Dysfunction
☐ Prostate Problems

LIFESTYLE STRESS LEVEL:
☐ High ☐ Moderate ☐ Minimal

☐ Diabetes? Please describe: _____
☐ Cancer? Please describe: _____

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: _____ Date: (D) _____ (M) _____ (Y) _____.