FLAMBOROUGH
Health Clinic

LESS PAIN. MORE POSSIBILITIES.

Dear Prospective Patient,

In order to save time during your initial visit, this file contains a copy of the new patient intake forms for Flamborough Health Clinic. Following this page, there should be a total of 3 pages of forms. Please complete them as thoroughly as possible.

To schedule your appointment, or should you need further clarification, please contact us at 905-481-0731.

Thank you for considering Flamborough Health Clinic. I look forward to working with you to achieve your health goals.

Sincerely,

Jared Wilbrink BSc, DC

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Patient File:	
Date:	

New Patient Form

Please complete this form completely. All information provided will be kept strictly confidential.

Personal Information

Title	Last Name	First Name	Middle Initial
Date of Birth YYYY/MM/DD	Sex ☐ Male ☐ Female	Marital Status ☐ M ☐ S ☐ W ☐ D ☐ Com Law	
Address			
City	Province	Postal Code	
Home #	Cell #	Email address	
May we contact you via email to remind you of appointments and notify you of up-to-date health and clinic information? ☐ Yes ☐ No			
Emergency Contact	Home #	Cell #	
How did you hear about us? ☐ A patient, who? ☐ Website ☐ Presentation ☐ Other			

Medical Contacts

Family Doctor	Phone #	Date of last visit YYYY/MM/DD	
Reason for last visit	OHIP #	Exp date YYYY/MM/DD	
May we contact your family physician to discuss or update your case? ☐ Yes ☐ No			
Previous Chiropractor	Reason for last visit		

Current Health History

Reason for consulting our office today ☐ Preventative or wellness type care ☐ Chronic condition ☐ New condition ☐ MVA ☐ WSIB

Current condition

When did this condition begin?	Has this occurred before? ☐ Yes ☐ No	
Other doctors/therapists seen for this condition ☐ Yes ☐ No	Who?	When?

Medications or treatments tried for this condition

Severity of Pain at its worst (please circle) 1=best 10=worst

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Severity of Pain now (please circle) 1=best 10=worst

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

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Current Health History (continued)

Please use the diagram below to indicate the problem areas

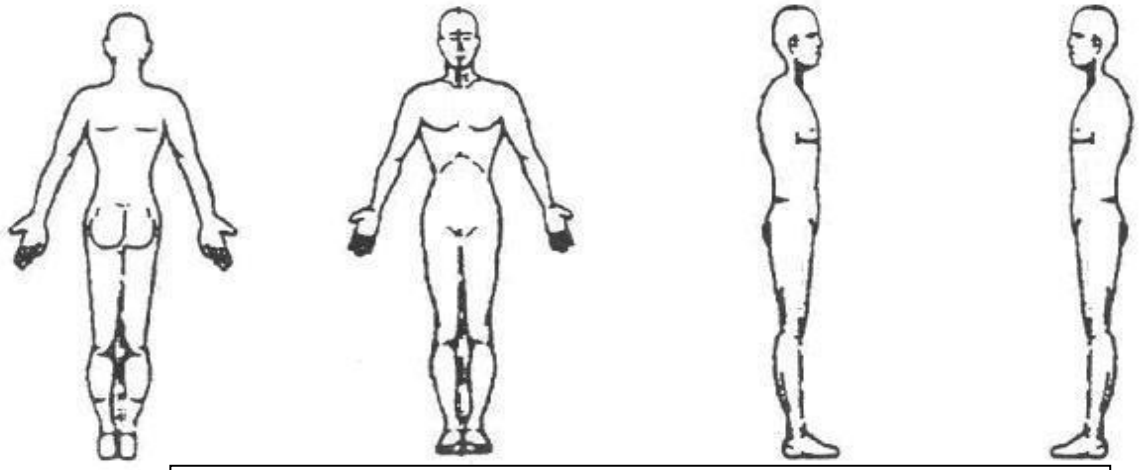

Diagram Key:

A=Achy S=Stabbing B=Burning P=Pins & Needles N=Numbing T=Stiff & Tight

Medications you currently take (**if you prefer, you may ask the receptionist to photocopy your list**):

_____ _____

_____ _____

_____ _____

Natural supplements you currently take (**if you prefer, you may ask the receptionist to photocopy your list**):

_____ _____

_____ _____

_____ _____

Past Health History

Please list any hospitilizations or surgical procedures, with the year that you had them

_____ _____

_____ _____

Please list any previous traumas (ie. MVA, work injuries, sports injuries, childhood traumas) with the year

_____ _____

_____ _____

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General Health History

This list of conditions may seem unrelated to the purpose of your appointment. However, these problems may influence your response to care.

Please check any conditions you currently have or have had in the past.

Musculoskeletal

- ☐ Headaches
- ☐ Hand pain
- ☐ Heel pain
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Foot pain
- ☐ Mid back pain
- ☐ Elbow pain
- ☐ Knee pain
- ☐ Jaw pain/clicking
- ☐ Low back pain
- ☐ Wrist pain
- ☐ Ankle pain
- ☐ General pain/stiffness

Nervous System

- ☐ Numbness in arm/hand
- ☐ Dizziness
- ☐ Anxiety/Depression
- ☐ Fainting
- ☐ Numbness in leg/foot
- ☐ Forgetfulness
- ☐ Paralysis
- ☐ Convulsions
- ☐ Muscle spasticity
- ☐ Muscle weakness

Viscera

- ☐ Heart problems
- ☐ Blood vessel problems
- ☐ Lung problems
- ☐ Lymphatic problems
- ☐ EENT problems
- ☐ Liver problems
- ☐ Stomach problems
- ☐ Esophagus problems
- ☐ Digestive tract problems
- ☐ Pancreas problems
- ☐ Appendix problems
- ☐ Spleen problems
- ☐ Kidney problems
- ☐ Bladder problems
- ☐ Female organ problems
- ☐ Male organ problems
- ☐ Immune system problems
- ☐ Skin problems
- ☐ Communicable disease
- ☐ Neurologic problems
- ☐ Muscle problems
- ☐ Bone problems

General

- ☐ Fatigue
- ☐ Allergies
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss
- ☐ Poor sleep

Personal satisfaction with diet ☐ Highly satisfied ☐ Satisfied ☐ Dissatisfied ☐ Highly dissatisfied

Do you have a regular exerise program? ☐ Yes ☐ No

Lifestyle stress levels ☐ High ☐ Moderate ☐ Very little

I certify that the information herein is, to the best of my knowledge, true and correct and I understand that it is my responsibility to inform Flamborough Health Clinic of any changes. I hereby authorize the Doctor to examine me understanding that such examinations can periodically lead to aggravation of symptoms. Further, I understand that information provided on this form and in the consultation/examination are part of my health record and are confidential.

Signature:_____ Date:_____

Patient or Parent/Guardian