Dr. Douglas Vlaskamp, D.C., Clinic Director, Chiropractor, Laser Therapist
118 Queen St. West, Suite 205, Brampton, ON, L6X 1A5 905-451-3963

New Patient Form - Chiropactic & Low Intensity Laser Therapy

PERSONAL INFORMATION

Last Name:___________________________________ First Name:____

Birth Date: _____ /______ / _________ / Age: _____ Gender: Male/Female
DAY MONTH YEAR

Address:____

City:____________________________ Province:_________ Postal Code:______________

Home Phone: (____) _______-________ Cell Phone: (____) _______-________ Work Phone: (____) _______-_________

Email address: ____

How would you like to be reminded of appointments? Home____ Cell ___ Work___ Email___

How did you hear about us? Family___ Friend ___ Co-Worker___ Internet ___ Doctor ___ Advertising ___

EMERGENCY CONTACT

Last Name:___________________________________ First Name:____

Relationship: Spouse____ Relative ___ Friend___

Home Phone: (____) _______-________ Cell Phone: (____) _______-________ Work Phone: (____) _______-_________

EMPLOYMENT INFORMATION

What kind of work do you do? ____

WSIB & AUTO INSURANCE CLAIMS

You will have to fill in the appropriate forms prior to treatment. Please advise the receptionist at front desk.

CONSENT TO BE EXAMINED BY THE CHIROPRACTOR

I consent to be examined by the chiropractor to help with my treatment. Examination may consist of range of motion tests, orthopedic tests, and hands on assessment of joint mobility and/or muscle tension or weakness. The Chiropractor will explain the steps of the examination. I understand that I may withdraw consent at any point and will let the Chiropractor know if I do not want him to proceed with the examination. Date: ________________________________

PATIENT NAME:____________________________________ PATIENT SIGNATURE: ________________________________
PLEASE PRINT

DC'S NAME: DR. DOUGLAS VLASKAMP, DC, Chiropractor DC'S SIGNATURE: ________________________________

CHIEF COMPLAINT – HISTORY OF PRESENT ILLNESS

Why are you here today?____

Body area(s) involved: Neck___ Back___ Head___ Ribs___ Pelvis___ Upper Extremity___ Lower Extremity___

Is this condition: New___ Recurrence___ Exacerbation___ Chronic___

How did injury occur? Slip or Fall ___ Overexertion ___ Repetitive Use ___ Slept Wrong ___ No Injury ___

Is this injury: Work Related ___ Auto Related___ (You will need to fill in additional forms)

Use the letters below to indicate TYPE and LOCATION of your sensations right now:

A=Aching

B=Burning

N=Numb

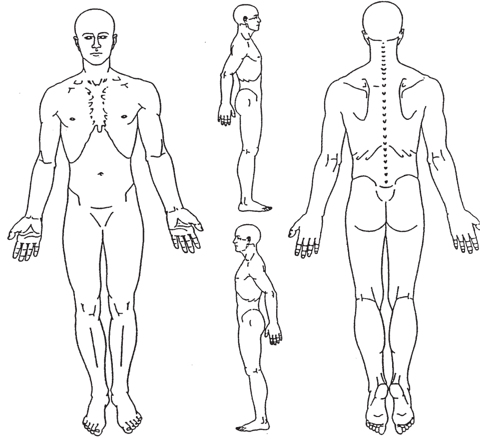
P=Pain

PN=Pins & Needles

ST=Stabbing

S=Stiffness

W=Weakness



Level of pain at REST: 0__ 1__ 2__ 3__ 4__ 5__ 6 __ 7__ 8__ 9__ 10__

Level of pain while ACTIVE: 0__ 1__ 2__ 3__ 4__ 5__ 6 __ 7__ 8__ 9__ 10__

Feels worse in the: Morning___ Afternoon___ Night ___

Feels worse with: Activity___ Sitting___ Standing___ Twisting___ Bending___ Walking___

Are you experiencing any of these symptoms?: Blurred Vision___ Dizziness___ Irritablity/Mood Swings___ Chronic Fatigue___

Localized Tingling___ Nausea___ Ringing In Ears___ Sleep Disturbance___ Cold Limbs___ Ecchymosis___

Fever___ Heartburn___ Joint Stiffness___ Muscle Spasm___ Muscle Weakness___ Pale Bluish Skin___

Panic___ Runny Nose___ Shortness of Breath___ Sweating___ Swelling___ Vomiting___

Does the pain radiate? Left___ Right___ Both Sides___ No Radiation___

Is there weakness present? Left___ Right___ Both Sides___ No Weakness___

Symptoms better with? Nothing___ OTC Meds___ RX Meds___ Cold___ Heat___ Massage___

Movement___ Sitting___ Standing___ Stretching___ Walking___

Do you suffer from any conditions other than what is listed above? ____

CURRENT MEDICATIONS

Medication_______________________Dosage______ For Which Condition?________________ For How Long?_________

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HEADACHES

Are you here for headaches? Yes___ No___

Location: Occipital___ Frontal___ Left Temporal___ Right Temporal___ Parietal___ Sinus___

Quality: Dull___ Sharp___ Throbbing___ Stabbing___ Aura___ No Aura___

Types: Hat Band___ Cluster___ Migraine___ Tension___

Other: How often?___________ How long?___________ What time of day?____________

Does the pain radiate? Yes___ No___ If Yes: Left___ Right___ Both___

Is body weakness present? Yes___ No___

FOOT PAIN

Are you here for foot pain? Yes___ No___

Location: _____________________________

Quality: _______________________________

HISTORY OF INJURIES Check ALL Injuries and Approximate Year

Back Injury _________ MVA _________ Broken Bones _________ Head Injury (loss of consciousness) _________

Head Injury (no loss of consciousness)_________ Soft Tissue Injury (mild)_________ Soft Tissue Injury (moderate)_________

Soft Tissue Injury (severe) _________ Fall(severe) _________ Joint Injury _________

Other____

HISTORY OF SURGERIES List ALL Surgical Procedures and Approximate Year

____

____

____

SOCIAL HISTORY

Diet: No Specific Diet___ High Fat___ High Fibre___ High Protein___ Low Calorie___ Low Carb___ Low Salt___ Other_______

Alcohol: Never___ Social Only___ How Many Drinks Per Week? ___

Tobacco: No tobacco Use___ Live With A Smoker___ Currently Smoke___ How Many Per Day___

FAMILY HISTORY (Check ALL that apply) List specific conditions.

Father: Alive___ Deceased___ No Significant Disease___ Has/Had____

Mother: Alive___ Deceased___ No Significant Disease___ Has/Had____

Brother(s): Alive___ Deceased___ No Significant Disease___ Has/Had____

Sister(s): Alive___ Deceased___ No Significant Disease___ Has/Had____

Son(s): Alive___ Deceased___ No Significant Disease___ Has/Had____

Daughter(s): Alive___ Deceased___ No Significant Disease___ Has/Had____

REVIEW OF ALL CURRENT HEALTH SYSTEMS

Constitutional: Chills___ Fatigue___ Night Sweats___ Weight Loss___ Daytime Drowsiness___ Fever___ Weight Gain___
I have none of the symptoms listed above___

Eyes & Vision: Wear Glasses/Contact___ Blindness___ Change In Vision___ Field of Vision Problems___ Light Sensitivity___
Blurred Vision___ Double Vision___ Glaucoma___ Tearing___ Cataracts___ Eye Pain__ Itching___
I have none of the symptoms listed above___

Ear/Nose /Throat: Ear Drainage___ Hearing Loss___ Ear Pain__ Ringing in the Ears___ Nosebleeds___ Post Nasal Drip___
Runny Nose___ Loss of Smell___ Nasal Congestion___ Snoring___ Frequent Sore Throat ___ Difficulty Swallowing___ Hoarseness ___
TMJ pain___ Dizziness ___ Headaches___
I have none of the symptoms listed above___

Respiration: Asthma___ Coughing up Blood___ Sputum Production___ Shortness of Breath___ Wheezing___
I have none of the symptoms listed above___

Cardiovascular: Angina___ High blood pressure___ Chest Pain___ Shortness of Breath With Exertion___ Low Blood Pressure___
Swelling of Legs___ Leg Pain with Activity___ Shortness of Breath Lying Down___ Heart Murmur___ Palpitations___
I have none of the symptoms listed above___

Gastrointestinal: Abdominal Pain___ Diarrhea___ Indigestion___ Vomiting Blood___ Belching___ Heartburn___ Nausea___ Ulcers___
Abnormal Stool Colour ___ Abnormal Stool Consistency___ Constipation___ Hemorrhoids___ Rectal Bleeding___
I have none of the symptoms listed above___

Females Only: Birth Control___ Cramps___ Irregular Menstruation___ Breast Lumps/Pain___ Frequent Urination___
Burning Urination___ Pregnancy___ Hormone Therapy
I have none of the symptoms listed above___

Males Only: Burning Urination___ Frequent Urination___ Prostate Problems___ Erectile Dysfunction___
I have none of the symptoms listed above___

Endocrine: Cold Intolerance___ Heat Intolerance___ Excessive Hunger___ Excessive Thirst___ Goiter___ Unusual Hair Growth___
Hair Loss___ Diabetes___
I have none of the symptoms listed above___

Skin: Changes in Nail Texture___ Itching___ Skin Lesions___ Changes in Skin Colour ___ Hives___ Varicosities___
I have none of the symptoms listed above___

Nervous System: Dizziness___ Limb Weakness___ Numbness___ Changes in Sensation___ Slurred Speech___ Tremor___
Facial Weakness___ Seizures___ Stress___ Unsteadiness___ Headache___ Memory Loss___ Sleep Disturbance___ Strokes___
I have none of the symptoms listed above___

Psychological: Behaviour Change___ Anxiety___ Depression___ Mood Change___ Insomnia___ Change in Appetite___
Confusion___
I have none of the symptoms listed above___

Allergy: Anaphylaxis ___ Rash___ Itching___ Nasal Congestion___ Sneezing___ Food Intolerance___
I have none of the symptoms listed above___

Hematologic: Anemia___ Blood Clotting___ Bruise Easily___ Lymph Node Swelling___ Bleeding___ Transfusion___
I have none of the symptoms listed above ___