



# KING LIBERTY HEALTH CENTRE "Believe in Natural Healing"

131 Jefferson Ave, Toronto, ON M6K 3E4

Tel: 647-350-2932 Fax: 416-516-5267 Email: [www.kinglibertyhealth@gmail.com](mailto:www.kinglibertyhealth@gmail.com)

[www.kinglibertyhealth.com](http://www.kinglibertyhealth.com)

*An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law. You will be asked to provide written authorization for release of any information*

## PATIENT INTAKE FORM

**Patient #:** \_\_\_\_\_

### Personal History

Date: \_\_\_\_\_

Name: \_\_\_\_\_

First Initial Last

Address: \_\_\_\_\_

Street Apt. City Province Postal Code

Home phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ Bus. phone: (\_\_\_\_) \_\_\_\_\_ X

e-mail \_\_\_\_\_ Would you like to receive newsletters and updates via email:  Y  N

Birth date: (dd/mm/yyyy) \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Chiro/Physio experience:  Y  N

Business/Employer \_\_\_\_\_ Extended Health Coverage:  Y  N AMT: \_\_\_\_\_

Type of Work: \_\_\_\_\_ **Circle one:** Married Single Divorced Separated Other

Name and number of emergency contact: \_\_\_\_\_

Referred to us by?: \_\_\_\_\_

### Current Health Condition:

What is your primary complaint?: \_\_\_\_\_

Other Health Professional seen for this condition:  Y  N Who? \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_ Has the condition occurred before:  Y  N

Is condition:  Job-related  Auto-related  Home injury  Fall  Other \_\_\_\_\_

Date of accident: (dd/mm/yyyy) \_\_\_\_\_ MVA:  Y  N WSIB:  Y  N Claim #: \_\_\_\_\_

What aggravates your condition?  Sitting  Standing  Bending  Lifting  Walking

Lying Down  Cold  Dampness  Other \_\_\_\_\_

What relieves your condition?  Bed rest  Ice  Heat  Massage  Medication

Other \_\_\_\_\_

Is your condition getting:  Worse  Constant  Comes and Goes  Better

Character of the pain:  Sharp  Dull  Ache  Pins and Needles  Numb

Burning  Constant  Intermittent  Other \_\_\_\_\_

Please describe how it feels when this problem is at its worst. \_\_\_\_\_

Please place an X on the grade indicating your severity of pain.

\_\_\_\_\_

No pain

The Worst Pain you can Imagine



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*Please check the conditions that you are currently experiencing, or circle the condition that you have experienced often in the past.*

### General Symptoms

- Headaches
- type: \_\_\_\_\_
- Loss of consciousness
- Blackouts
- Fever
- Sweats
- Fainting
- Dizziness
- Clumsiness
- Convulsions
- Loss of sleep
- Numbness, pain or tingling
- Nervousness
- Loss of weight

### Respiratory

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficulty breathing

### Cardiovascular

- High blood pressure
- Low blood pressure
- Poor circulation
- Heart disease
- Angina
- Stroke
- Varicose veins
- Pain over heart
- Hardening of arteries
- Swelling of ankles
- Bleeding disorders

### Infections

- Herpes
- Hepatitis
- Plantar warts
- TB
- HIV, AIDS
- Other: \_\_\_\_\_

### **Have you ever been in a car accident?**

Y  N When: \_\_\_\_\_

### **Have you ever been hospitalized?**

Y  N Reason: \_\_\_\_\_

### **Are you currently a smoker?**

Y  N

### Skin

- Skin conditions
- type: \_\_\_\_\_
- Bruise easily
- Rashes, itching
- Dryness
- Boils
- Hives

### Muscles and Joints

- stiff neck
- back ache
- swollen joints
- Painful tailbone
- Foot trouble
- Shoulder pain
- Arm/Forearm pain
- Elbow pain
- Wrist pain
- Hand pain
- Arthritis
- affected areas \_\_\_\_\_
- Jaw (TMJ) pain or clicking
- Weakness or loss of strength

### E.E.N.T.

- Blurred vision
- Failing vision
- Crossed eyes
- Double vision
- Eye pain
- Deafness
- Earache
- Ringing, buzzing, any noise in ears
- Asthma
- Frequent Colds
- Sinus infection
- Enlarged glands
- Enlarged thyroid
- Slurred or other speech problems
- Difficulty swallowing
- Dental problems

### Previous Chiropractor/Physiotherapist/Massage

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

### Medical Doctor

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

**X-rays in last 6 months:**  Y  N

Region(s) \_\_\_\_\_

**Have you ever had any fractures?**  Y  N

Region(s) \_\_\_\_\_

### Current Medications

| Name  | For what condition? |
|-------|---------------------|
| _____ | _____               |
| _____ | _____               |
| _____ | _____               |
| _____ | _____               |

### Genitourinary

- trouble urinating
- Blood in urine
- Kidney infection
- Bed wetting
- Prostate trouble
- Sexual dysfunction

### Gastrointestinal

- Indigestion
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting (blood?)
- Pain over stomach
- Constipation
- Diarrhea
- Hemorrhoids (piles)
- Jaundice
- Gall bladder trouble
- Intestinal worms
- Ulcer
- Diabetes
- Poor appetite

### Women

- Painful
- Excessive Flow
- Hot Flashes
- Irregular cycle
- Cramps or backache
- Vaginal discharge
- swollen breasts
- Lumps in breasts

**Have you ever been on birth control?**  Y  N

**Are you currently taking the birth control pill?**  Y  N

# of pregnancies: \_\_\_\_\_

# of children: \_\_\_\_\_

**Are you Pregnant?**  Y  N

Due date: \_\_\_\_\_

### Lifestyle Stress Level

- High
- Moderate
- Very Little

### **Have you ever had surgery?**

Y  N Type: \_\_\_\_\_

### **Have you ever smoked in the past?**

Y  N

### **Have you ever been diagnosed with Cancer?**

Y  N Type: \_\_\_\_\_

### **Do you have a regular exercise program?**

Y  N



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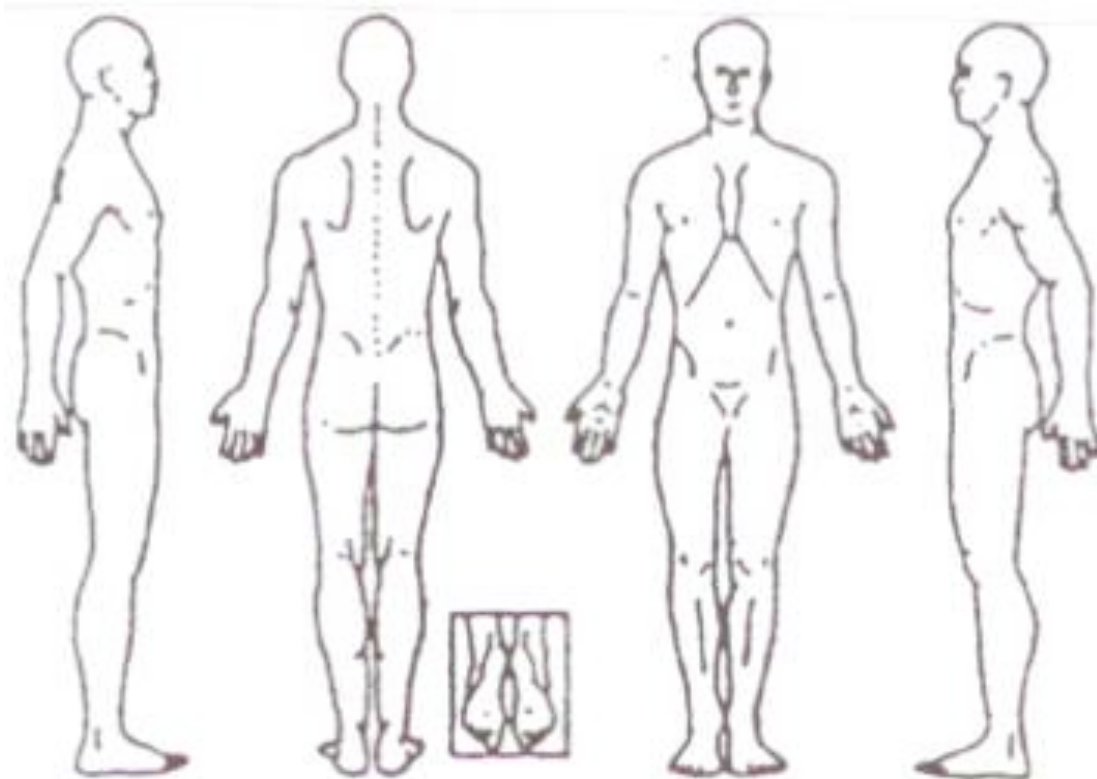
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Patient Name: \_\_\_\_\_

**Patient #:** \_\_\_\_\_

Date: \_\_\_\_\_

## **SYMPTOM DIAGRAM**



In the diagram provided, please mark the areas on your body, which you feel represent the pain(s) or sensation(s) you are experiencing. Please include all area. You may use the symbols provided below.

|          |               |        |                  |         |
|----------|---------------|--------|------------------|---------|
| Symbols: | Numbness      | nnnnnn | Pins and Needles | .....   |
|          | Burning       | xxxxxx | Stabbing & Sharp | sssssss |
|          | Dull & Aching | >>>>>  | Stiff & Tight    | +++++   |



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## **INFORMED CONSENT TO CHIROPRACTIC ASSESSMENT AND TREATMENT**

Doctors of chiropractic, medical doctors, and physiotherapists who use manual therapy techniques are required to advise patients that there are or may be some risk associated with treatment. 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 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 following cervical and lumbar spinal adjustment, although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or 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 had the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general (including spinal adjustments), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to my present condition(s) and any future condition(s) which I seek chiropractic care.

### **TO BE COMPLETED BY THE PATIENT:**

\_\_\_\_\_  
PATIENT'S NAME (PLEASE PRINT)

\_\_\_\_\_  
SIGNATURE OF PATIENT  
(OR PARENT/GUARDIAN)

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
WITNESS TO SIGNATURE ABOVE