10 Falconer Drive, Unit 2 Mississauga ON. L5N 3L8 Phone: 905-997-8337

Patient Information

Date (MM/DD/YY): _____

First Name: _____ **Last Name:** _____ **Sex:** ◯ **M** ◯ **F**

Birthday (MM/DD/YY): _____ **Age:** _____ **Email:** _____

Home Address: _____

City: _____ **Postal Code:** _____ **Phone:** _____

Emergency Contact Name: _____

Phone Number: _____ **Relationship to you:** _____

How did you learn about Elite Physio? _____

Occupation: _____

Work Telephone: _____ **May the Doctor and/or Staff contact you at work?** ◯ **Yes** ◯ **No**

Who is your current General Practitioner (MD)? _____

Clinic Name and Address: _____

Are you seeing a Medical Specialist? ◯ **Yes** ◯ **No, Reason for seeing Specialist.** _____

Main Health Complaint: _____

Other Complaints: _____

Have you had previous care from a: ◯**Chiropractor** ◯ **Massage Therapist** ◯ **Physiotherapist**

Did it help? ◯ **No** ◯ **A little** ◯**Moderately** ◯ **Extremely**

Have you had any recent X-rays, CT Scans or MRI? ◯ **Yes** ◯ **No** **If yes, when:** ◯ _____

Please list any hospitalizations, surgeries or major accidents (including MVA's) you've had and the date:

_____

10 Falconer Drive, Unit 2 Mississauga ON. L5N 3L8 Phone: 905-997-8337

Confidential Health Information

Name: _____ **DOB:** ____/____/____/

Please list any medications or supplements you are taking and state reasons: _____

_____

List and date any significant physical trauma in the past (MVA, Falls, etc.): _____

_____

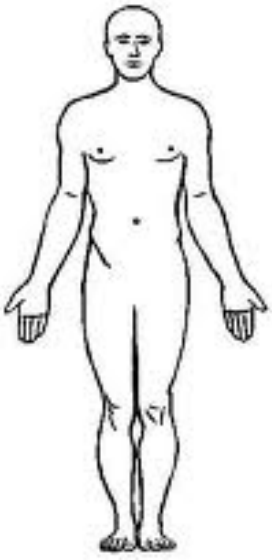
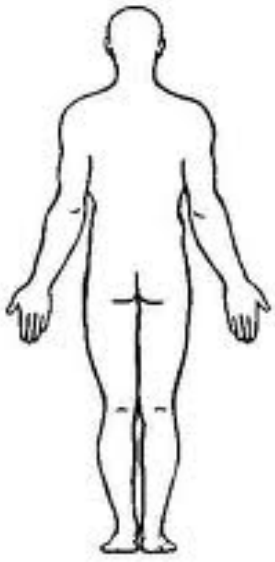
How often do you exercise: _____ **Type of exercise?** _____

Do you currently smoke? ◯ Yes ◯ No **How long have you smoked?** _____

For Women

Are you pregnant: ◯ Yes ◯ No ◯Trying **If yes, due date?** _____
Do you have children? ◯ Yes ◯ No **If yes, by:** ◯Natural ◯Caesarean
Menstrual Cycle: ◯Regular ◯Irregular ◯Cramps ◯Painful Cycle
Date of your last breast exam: _____

To obtain a complete picture of your overall health, please complete the following form and mark on the diagram the areas where you feel pain.

◯Insomnia	◯Alcohol/Drug abuse		
◯Fatigue	◯Eating disorders		
◯Unexplained weight loss	◯Heart condition		
◯Concussion	◯Cancer/tumor		
◯Headache	◯Osteoporosis		
◯Dizziness	◯Hepatitis		
◯ Asthma	◯AIDS/HIV		
◯Difficulty breathing	◯High/Low blood pressure		
◯Fainting	◯Rheumatic arthritis		
◯Muscle weakness	◯Chronic fatigue		
◯Numbness	◯Diabetes		
◯Tingling sensation	◯Thyroid problems		
◯Stroke	◯Incontinence		
◯Seizures/epilepsy	◯Urinary urgency		
◯Night sweats	◯Excessive sweating		
◯Depression	◯Parkinson's		
◯Anxiety/nervousness	◯Multiple sclerosis		