DR. BRIAN DOWER ~ CHIROPRACTOR
28 PARK ROAD, TORONTO, ONTARIO, M4W 1M1 ~ TEL (416) 920-7275 FAX (416) 920-7274

UPDATED PATIENT INFORMATION

Please fill in your name and other information that may need to be changed or updated in our files.

_____
Today's Date (dd/mm/yy)

_____ _____
Last Name First Name

_____ _____ _____ _____ _____
Apt # Address City Province Postal Code

_____ _____ _____
Home Phone Cell Phone E-Mail Address

_____ _____
Emergency Contact Name Emergency Contact's Phone

_____ _____
Your Occupation and Employer Work Phone May we contact you at work? ◎ Yes ◎No

Your preferred method of contact: ◎ Home Phone ◎ Cell Phone ◎ E-mail ◎Work Phone

_____ _____
Medical doctor's name Medical doctor's phone or address

UPDATED PATIENT HISTORY

Please select one:

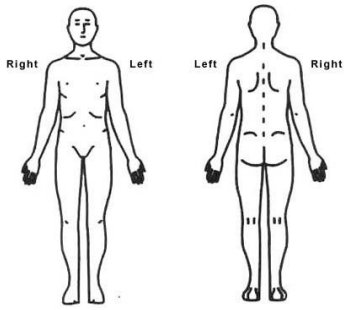
◎**Progress evaluation**	I've been under active care and this is a periodic re-evaluation.
◎**New Condition**	I've been under care and a new or returning condition has emerged.
◎**Maintenance Patient**	I'm under maintenance care with a new or returning health issue.
◎**Returning Patient**	After a period of inactivity, I've had a relapse or an all-new health issue.

1. Current symptoms:

_____

_____

2. Location (Where does it hurt?)



_____

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3. Quality of Symptoms (What does it feel like?)

⊙ Numbness	⊙ Aching	⊙ Burning
⊙Tingling	⊙ Cramps	⊙ Shooting
⊙ Stiffness	⊙ Nagging	⊙ Stabbing
⊙ Dull	⊙ Sharp	⊙ Other _____

4. Intensity (How extreme are your current symptoms?)

0 {⊙ ----------⊙ ----------⊙ ----------⊙ ---------⊙ ----------⊙ ----------⊙ ----------⊙ --------⊙ ----------⊙} **10**

{Absent Uncomfortable Agonizing}

5. Duration and Timing (When did it start and how often are your current symptoms?)

_____ ⊙ Constant ⊙ Comes and goes

6. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel?)

_____

7. Aggravating or relief factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem?_____

What tends to lessen the problem?_____

8. **Prior interventions** (What have you done to relieve the symptoms?)

⊙ Prescription medication	⊙Surgery	⊙ Ice
⊙ Over the counter drugs	⊙Acupuncture	⊙Heat
⊙ Homeopathic remedies	⊙ Chiropractic	⊙ Others_____
⊙ Physiotherapy	⊙Massage	

9. Is this a work related or motor vehicle accident related injury? ⊙Yes ⊙ No

10. Have you had x-rays taken? ⊙ Yes ⊙ No

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11. **Review of systems** (Identify changes since your most recent evaluation with us): **Worse No Change Improved**

a. Musculoskeletal System- osteoporosis, arthritis, neck and back pain, poor posture, etc. ----------⊙--------⊙----------⊙
b. **Neurological System**- anxiety, depression, headaches, dizziness, pins and needles, etc. ----------⊙--------⊙----------⊙
c. Cardiovascular System- high or low blood pressure, high cholesterol, angina, etc. ----------⊙--------⊙----------⊙
d. Respiratory System- asthma, apnea, emphysema, hay fever, shortness of breath, etc. ----------⊙--------⊙----------⊙
e. Digestive System- anorexia/bulimia, ulcer, food sensitivities, diarrhea, indigestion, etc. ----------⊙--------⊙----------⊙
f. Sensory System- blurred vision, ringing in ears, hearing loss, chronic ear infections, etc. ----------⊙--------⊙----------⊙
g. Skin System- skin cancer, psoriasis, eczema, acne, hair loss, rash, etc. ----------⊙--------⊙----------⊙
h. Endocrine System- thyroid issues, immune disorders, hypoglycemia, frequent urination, etc.--------⊙--------⊙----------⊙
i. Genitourinary System- kidney stones, infertility, bedwetting, prostate issues, PMS, etc. ---------⊙--------⊙----------⊙
j. Constitutional System- fainting, low libido, poor appetite, fatigue, sudden weight, etc. ------⊙--------⊙----------⊙

12. **Illnesses, operations, injuries or treatments since your most recent visit?**

_____
_____

13. What else should Dr. Dower know about your current condition?

_____
_____

14. Medications and supplements (please list ALL prescription, over-the-counter-drugs and supplements/vitamins):

_____
_____

15. Social History (Tell Dr. Dower about your health and stress levels.)

Alcohol use	⊙ Daily	⊙ Weekly	How much? _____
Caffeine use	⊙ Daily	⊙ Weekly	How much? _____
Tobacco use	⊙ Daily	⊙ Weekly	How much? _____
Exercising	⊙ Daily	⊙ Weekly	How much? _____
Pain relievers	⊙ Daily	⊙ Weekly	How much? _____
Soft drinks	⊙ Daily	⊙ Weekly	How much? _____
Water intake	⊙ Daily		How much?_____

Hobbies: _____

Meditation?	⊙Yes	⊙ No
Yoga?	⊙Yes	⊙ No
Job pressure/stress?	⊙Yes	⊙ No
Financial peace?	⊙Yes	⊙ No
Recreation drugs?	⊙Yes	⊙ No
Energy levels low?	⊙Yes	⊙ No

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16. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	⊙	⊙	⊙	⊙
Rising out of chair	⊙	⊙	⊙	⊙
Standing	⊙	⊙	⊙	⊙
Waking	⊙	⊙	⊙	⊙
Lying down	⊙	⊙	⊙	⊙
Bending over	⊙	⊙	⊙	⊙
Climbing stairs	⊙	⊙	⊙	⊙
Using a computer	⊙	⊙	⊙	⊙
Getting in/out of car	⊙	⊙	⊙	⊙
Driving car	⊙	⊙	⊙	⊙
Looking over shoulder	⊙	⊙	⊙	⊙
Caring for family	⊙	⊙	⊙	⊙
Household chores	⊙	⊙	⊙	⊙
Lifting object	⊙	⊙	⊙	⊙
Reaching overhead	⊙	⊙	⊙	⊙
Showering or bathing	⊙	⊙	⊙	⊙
Dressing myself	⊙	⊙	⊙	⊙
Love life	⊙	⊙	⊙	⊙
Getting to sleep	⊙	⊙	⊙	⊙
Staying asleep	⊙	⊙	⊙	⊙
Concentrating	⊙	⊙	⊙	⊙
Exercising	⊙	⊙	⊙	⊙

17. Is there <u>anything</u> else Dr. Dower should know about your current condition, your progress, or ways your current condition is affecting your life?

_____

_____

_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my heath concern.

_____ _____

Signature **Date**