Valentino Chiropractic Clinic
332 Browns Line
Etobicoke, ON. M8W 3T6
Tel: 416-259-4911 Fax: 416-259-1824

PATIENT INFORMATION

First Name _____ **Last Name** _____

Address _____ **City** _____ **Province** _____ **Postal Code** _____

Home Phone _____ **Work Phone** _____**ext**_____ **Cell Phone** _____

E-Mail Address: _____

Marital Status: M S D W **Birth Date: DD/MM/YY**_____ **Age** _____

Work Status: ☐Employed (FT/PT) ☐Retired ☐Student ☐ Unemployed
Company where employed: _____

Hobbies: _____

What is your **primary** complaint? _____

Other complaints? _____

Have you consulted with other doctor's for your present condition(s)? _____If yes, whom? _____

Name of Family Doctor: _____ When was your last Physical Examination? _____
Do you or your spouse have Extended Health Care Insurance? ☐ Yes ☐ No
Name of Insurance Co._____

How were your referred? ☐Patient ☐ Drive By ☐Yellow pages ☐ Sign ☐Flyer ☐Website ☐ internet search
other: _____

Is your problem related to an injury? ___Yes ___No
Is your problem related to a: ___Car Accident ___ Slip/Fall ___ Work related ___ other
If other Describe_____

In Case of Emergency contact: _____ Phone # _____

Have you ever been to a chiropractor before? ___Yes ___No
If yes, whom? For what condition?
_____
Date of Last Adjustment: _____

Continued on Back…please flip over>>>

When did your present complaint start? _____
Is it getting better? Worse? Staying the same? _____
Have you had this complaint before? If yes, when? _____
Anything make it better? _____
Anything make it worse? _____
Can you describe the quality of the pain? (Ex: sharp, dull, shooting…)_____
Does the pain travel anywhere else? _____
Is it worse at any point during the day? _____

On a scale of 0-10, I rate my *discomfort or pain* as: (mark an X)

0 _____ 10
No pain severe pain

On a scale of 1-10 what is your *STRESS* level today? (Mark an X)

0 _____ 10
No Stress High Stress

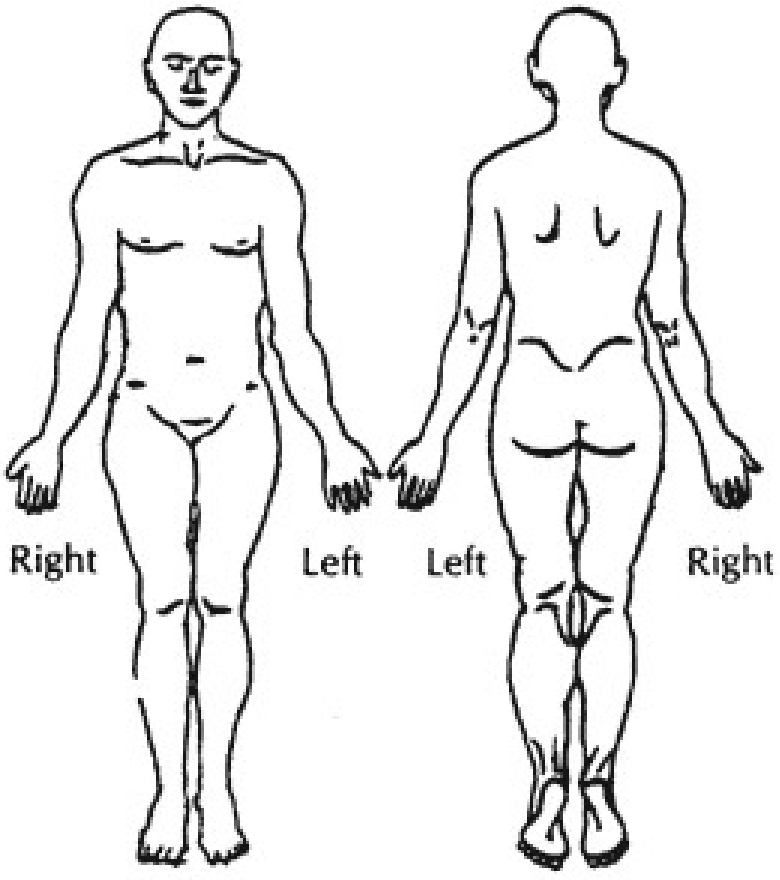
Place X's on the area that you have *pain or discomfort* on the picture below:

Your Height:

_____Ft ___ inches
_____cm

Your Weight:

_____lbs
_____kgs



Date_____ **Signature_____**

Valentino Chiropractic Clinic

Patient Name _____ **Date**_____

The items below may relate to your current condition. In the space in front of each item, put a **Y** if you have had the problem **WITHIN THE LAST YEAR** and an **N** if you have **NEVER HAD** the problem.

GENERAL

1. _____fever
2. _____Chills
3. _____Night sweats
4. _____Loss of sleep
5. _____Fatigue
6. _____Nervousness
7. _____Weight loss or gain
8. _____Allergies
9. _____Bleeding problems
10. _____Anemia
11. _____Diabetes
12. _____Cancer
13. _____Thyroid disease/Goiter
14. _____Alcoholism
15. _____Drug Abuse

EAR, EYE, NOSE, THROAT

16. _____Poor vision
17. _____Pain in Eye(s)
18. _____Deafness/Difficulty Hearing
19. _____Nosebleeds
20. _____Nose problems
21. _____Sinus Trouble
22. _____Dental Problems
23. _____Hoarseness
24. _____Tonsillectomy

GASTROINTESTINAL

25. _____Poor Appetite
26. _____Poor Digestion
27. _____Difficulty Swallowing
28. _____Belching or Gas
29. _____Frequent Nausea
30. _____Vomiting
31. _____Vomiting blood
32. _____Pain over the abdomen
33. _____Ulcer
34. _____Black or bloody stools
35. _____Liver problems
36. _____Gall Bladder problems
37. _____Jaundice
38. _____Hernia
39. _____Diarrhea
40. _____Constipation
41. _____Hemorrhoids
42. _____Appendicitis

MEN ONLY

43. _____testicular swelling/Pain
44. _____Prostate Problems

RESPIRATORY

45. _____Difficulty in Breathing
46. _____Chronic cough
47. _____Spitting Phlegm
48. _____Spitting blood
49. _____Wheezing/Asthma
50. _____Pneumonia
51. _____Tuberculosis

CARDIOVASCULAR

52. _____Irregular Heartbeat
53. _____High blood pressure
54. _____Pain over the heart
55. _____Previous heart trouble
56. _____Ankle swelling
57. _____Varicose Veins
58. _____Rheumatic Fever
59. _____Stroke

GENITOURINARY

60. _____Frequent Urination
61. _____Painful urination
62. _____Blood in Urine
63. _____Kidney Disease
64. _____Urinary infection
65. _____Inability to control Urination
66. _____Difficulty starting urine flow
67. _____Get up at night to urinate
68. _____Breast lump or pain
69. _____Venereal infection
70. _____sexual difficulties

SKIN

71. _____Itching
72. _____bruise easily
73. _____Change in Mole
74. _____Skin Cancer
75. _____scars

NEUROLGIC

76. _____Weakness
77. _____Twitching
78. _____Headache
79. _____Fainting
80. _____Dizziness
81. _____Convulsions
82. _____Epilepsy/Seizures
83. _____Numbing/Tingling
84. _____Arm/Leg Pain
85. _____mental disorder
86. _____tremors

MUSCULOSKELETAL

87. _____Neck stiffness/Pain
88. _____Pain between shoulders
89. _____Low Back Pain
90. _____Swollen Joints
91. _____Painful Joints
92. _____Muscle aches/soreness
93. _____Arthritis
94. _____spinal curvature

WOMEN ONLY

95. ____Painful periods
96. ____Excessive Flow
97. ____Irregular cycles
98. ____Vaginal burning/itching
99. ____Hot flashes
100. ____Date last period began:____
101. ____Date of last Pap smear:____

EXERCISE

102. _____None
103. _____1-2 times/wk
104. _____3-5 times/wk
105. _____6-7 times/wk

HABITS

106. _____smoking ___#packs/day
107. _____Drinking
108. _____Recreational drug use
109. _____caffeine

FAMILY HISTORY: include siblings, grandparents, and parents (do not include yourself)

110. _____Diabetes
111. _____Thyroid Disease/goiter
112. _____Tuberculosis
113. _____Kidney disease
114. _____High blood pressure
115. _____Heart disease
116. _____Cancer
117. _____muscle, bone or nerve disease
118. _____Lung disease
119. _____Ulcers
120. _____Arthritis
121. _____Seizures
122. _____Strokes

MISCELLANEOUS

_____
_____
_____
_____
_____
_____
_____
_____

Valentino Chiropractic Clinic Office Policy

Throughout your treatment, Dr. Valentino will recommend a schedule of care. Your schedule of care is based on results. If we don't see you often enough, our ability to reduce negative patterns in your spine is impaired. Dr. Valentino's recommendations are designed to produce the greatest results in the shortest amount of time, that's why keeping your appointments is so important.

We recognize that your time is just as valuable as ours. It is our mission to not make you wait for your appointment.

However, in the event that you need to cancel or reschedule your appointment, we require 24 hours for **ALL CANCELLATIONS and RESCHEDULED appointments**. **Failure to provide 24 hours' notice will result in a Missed Appointment Fee of $25.**

By signing below, I agree to the terms above and I have been given the opportunity to have my questions answered by Dr. Valentino and fully understand the above office policy. **I understand that repeated cancellations of appointments and non-adherence to my schedule of care may result in the termination of treatment by Dr. Valentino**.

Printed Name: _____

Signature: _____

Date: _____

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