Kingsbury Family Chiropractic
Dr. Zoran Zivkovic

Welcome to Our Clinic

How would you like to be addressed? _____

Confidential Case History – General Information

Name _____ Date _____

Address _____City _____Postal Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____

Occupation _____ Employed by _____

Date of Birth _____/_____/_____(dd/mm/yyyy) Age ____ Sex □ M □ F

Marital Status □Single □Married □Divorced□ Widowed Spouse/Partner Name _____

Children? □ Y □ N Names/Ages _____

Medical Doctor _____ Extended Coverage □ Y □ N

For Females only: Are you pregnant □ yes □ no □ not sure Date of last Menstruation: _____

Health History

Your main complaint _____

Secondary complaint _____

When did this start? _____ in the last month: Better/Worse/Same

Have you suffered with this before? □ Y □ N If yes, when? _____

If you have pain, please describe: (please circle)
Sharp / Radiating / Stabbing / Throbbing / Aching / Other _____Is it Constant /Frequent /Occasional

On a scale of 1 to 10 (with 10 being the worst) How would your rate your pain? _____

Do you experience numbness/tingling in your: Hands/fingers/feet/toes? (circle)

How does this problem interfere with work, family, hobbies, life? _____

What do you do that makes this problem worse?_____

What gives some relief? _____

On a scale of 1 to 10 with 10 being the most; how committed are you to helping us solve this problem _____

Have you ever suffered from any of the following?

	Y	N		Y	N		Y	N		Y	N
Thyroid	□	□	Tuberculosis	□	□	Emotional Problems	□	□	Psoriasis	□	□
Diabetes	□	□	Pneumonia	□	□	Epilepsy	□	□	Polio	□	□
Asthma	□	□	Back Pain	□	□	High Blood Pressure	□	□	Cancer	□	□
Heart Disease	□	□	Headaches	□	□	Venereal Disease	□	□	Arthritis	□	□
Allergies	□	□	Ulcers	□	□	Alcoholism	□	□	HIV	□	□

Office Use Only:_____

Referral Source:_____ MVA ____ WSIB ____ Date of Injury _____

Previous Chiropractic Care: ____ Y ____ N _____ _____

Please list any significant illness, operations, accidents, falls:

Date:	Occurrence
1	
2	
3	
4	

Please check any of the following symptoms if you have experienced them in the last 3 months:

C1-C3

□headaches and migraine like pain
□dizziness
□ringing in ears
□reoccurring sore throat
□nasal congestion
□symptoms of dyslexia
□vertebral artery insufficiency
□neck/scalp tension
□light headedness
□problems with memory
□sleep issues
□sinus trouble
□generalized fatigue
□loss of concentration
□pressure/pain behind eyes
□low/high blood pressure
□jaw pain
□depression
□loss of co-ordination
□childhood fevers
□allergies/hay fever
□blurring of vision
□facial pain
□ear pain
□irritability
□disorientation
□insomnia
□fainting

C4-C7

□pain/stiffness in neck
□numbness/tingling in hands/fingers
□wasting of arm & shoulder muscles
□reduced neck/shoulder movement
□loss of power and grip strength
□shoulder, arm or hand pain
□bursitis in shoulder
□twinges of pain
□chest pain
□poor circulation in the arms
□tennis elbow-like pain
□difficulty swallowing
□nervousness
□cold hands
□speech difficulties
□hand/finger swelling
□whiplash
□neck tension
□thyroid problems
□hormonal imbalances

T1-T3

□rapid or slow heart beat
□asthma & like conditions
□functional heart conditions
□pain between shoulder blades
□chest pain/pressure
□heart arrythmias
□rib pain
□bronchitis/respiratory difficulties
□difficult breathing
□angina-like pain
□recurring upper respiratory tract infections
□shortness of breath

T4-T9

□pain between shoulder blades
□jaundice is infant
□heartburn
□acne & other skin disturbances
□trouble digesting certain foods
□chest pain & pain in ribs
□stomach trouble
□abdominal bleeding
□abdominal pain
□abdominal bloating
□liver & gall bladder trouble
□chronic indigestion
□pancreas malfunction
□allergies
□sweet tooth cravings
□ulcers
□dyspepsia
□hypoglycaemia
□gastritis

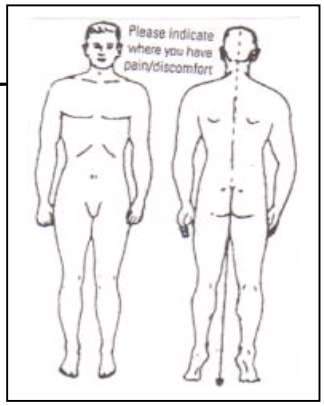
T10-L1

□urinary problems
□lazy colon
□abdominal bloating & pain
□allergies
□constipation
□adrenal trouble
□gas pains
□mid-back pain
□ulcerative intestinal conditions
□appendicitis-like pain
□frequent sighing
□anxiety/depression
□spastic colon
□diarrhea
□fluid retention
□fatigue

L2-L5

□low back pain
□poor circulation in legs
□constipation
□bed wetting in children
□menstrual cramps
□urinary difficulties
□spinal curvature scoliosis
□ulcerative bowel conditions
□groin pains
□leg pains
□impotence
□abdominal cramps
□sciatica
□knee pains
□too frequent urination
□bladder & prostate problems
□cramping
□childhood “growing pains”
□numbness in legs & feet
□fatigue when standing
□leg & ankle swelling
□leg weakness & fatigue
□hemorrhoid pain
□gas pain
□infertility
□cold feet
□varicose veins
□weakness in legs

Please list your medications:_____



INFORMED CONSENT TO ADJUSTMENTS, CARE, RADIOLOGY

Physician, Chiropractors, Osteopaths and Physiotherapists are required to advise patients of benefits and risks including sprain/strain, rib fracture, disc herniation and with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays are performed on you to minimize these risks to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions.
If you have any questions about this, please ask your chiropractor.
If you read the above statement and consent to treatment.

Signed_____Date_____

Your family’s health potential is our passion.