Dr. Shaheed Rahman, B.Sc., D.C.
Dr. Graeme Copeland, B.Sc., D.C.
8-90 Frobisher Dr. Waterloo ON N2V 2A1

PATIENT INFORMATION

Thank you for choosing our clinic for your healthcare needs. Please complete the following information. Please answer ALL questions even if they may seem unrelated to your condition(s)

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

OHIP health card number: _____ Social Ins. Number (for WSIB only): _____

NAME: _____

ADDRESS : _____ CITY/TOWN: _____ Postal Code: _____

Telephone: home: _____ work: _____ cell: _____

Gender: M / F Date of Birth (dd/mm/yy): _____ Age: _____ Marital Status: _____

Occupation/Job Title: _____ Employer: _____

Emergency contact person: _____ Relation: _____ phone: _____

How did you hear about our office : □ Referred □ other _____

Name of Referral: _____

Do you have a family medical doctor: □ yes □ no

MD name: _____ Address: _____ phone: _____

Prior Chiropractic Care : □ yes □ no

Chiropractor name: _____ Address: _____ date of last appt: _____

Prior X-rays/diagnostic imaging (CT scan/MRI): □ yes □ no _____ Result: _____

Please complete this section ONLY if due to a motor vehicle accident or work related (WSIB) injury:

□ Motor Vehicle Accident □ WSIB

Claim Number: _____ Insurance Company: _____

Adjudicator / Adjuster Name: _____ Telephone: _____

Have you missed any time at work due to your injury: □ yes □ no

Currently working: □ yes □ no

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PATIENT INFORMATION FORM

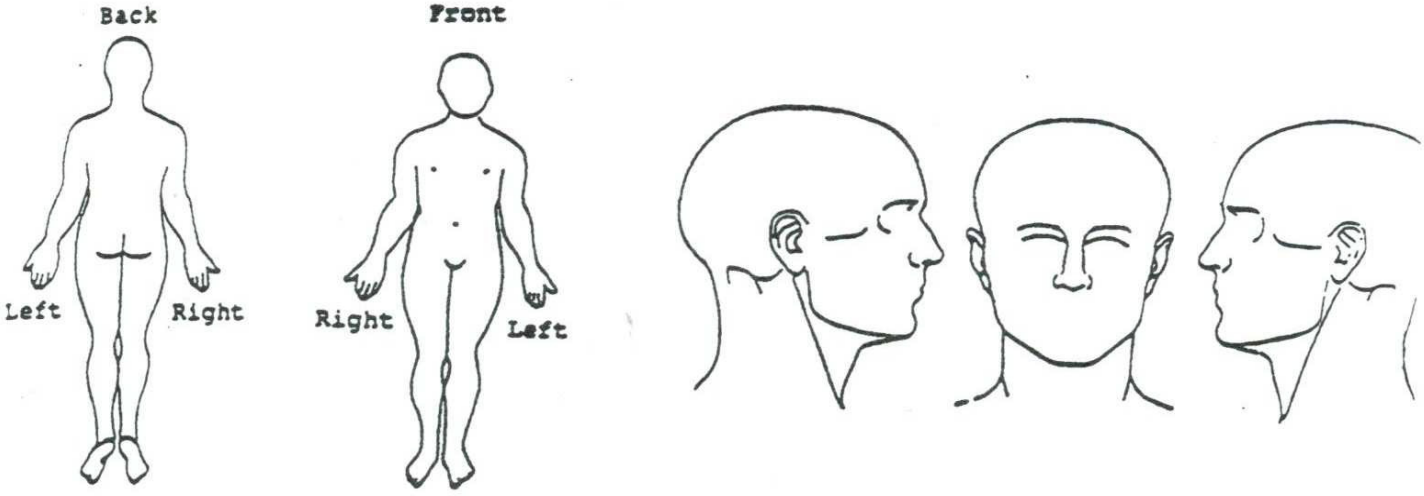
Patient Name: _____ **Date:** _____

Dr. Shaheed Rahman

1. Describe your present symptom(s)

2. On the following diagrams, indicate the location of your complaint(s), using the symbols

A=ACHE B=BURNING N=NUMBNESS
P=PINS AND NEEDLES S=STABBING O=OTHER



3. The lines below represent the intensity of the pain described above. Please MARK an "X" at the position on the scale which indicates how much pain you feel at this time.

Low Back Pain
no pain _____ worst pain imaginable

Mid Back Pain
no pain _____ worst pain imaginable

Neck Pain
no pain _____ worst pain imaginable

Other Pain
no pain _____ worst pain imaginable

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Patient Name: _____

8-90 Frobisher Dr Waterloo
ON N2V2A1

Medications	Dosage	Condition taken for

Surgeries	Date	Reason

PAST/PRESENT MEDICAL HISTORY, FAMILY HISTORY INFORMATION

Please checkmark any of the symptoms/conditions below that you may have has in the past or presently experiencing. Family History refers to conditions prevalent in your parents, siblings, aunts/uncles. **Only the first box is for family history.**

Family History (parents, etc.)	Eyes/Ears/Nose/Throat	Smoking History
_____ Diabetes	_____ Pain in Eyes	
_____ Kidney Disease	_____ Ringing in Ears	_____ Cigarettes
_____ Thyroid problems	_____ Difficulty with smell	_____ Number daily
High blood pressure	Sinusitis	Number of years
_____ Heart disease	_____ Other	_____ Tobacco Chewing
_____ Stroke	_____	_____ Cigars
_____ Cancer		
OTHER	**Gastrointestinal**	**Cardiovascular**
General History	_____ Nausea/Vomiting	_____ High Blood Pressure
_____ Trauma/Injuries	_____ Abdominal pain/Swelling	_____ Heart Disease
_____ Weight change	_____ Change in Stool colour	_____ Myocardial Infarctions
_____ Fever/chills	_____ Gallbladder/Liver disease	_____ Shortness of breath with exercise
Sweats	Pancreatitis	Chest pain/discomfort
_____ Anemia	_____ Daily alcohol intake	_____ Palpatations
_____ Bleeding		_____ Edema / Swelling
Allergies		_____ Calf pain with walking
Endocrine System	**Respiratory System**	
_____ Diabetes	_____ Difficulty Breathing	_____ OTHER:
_____ Thyroid problems	_____ Wheezing/Asthma	_____
_____ OTHER:	_____ Cough/Blood in Sputum	
	Pneumonia/Emphysema	

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Name: _____

Dr. Shaheed Rahman

8-90 Frobisher Drive
Waterloo N2V 2A1

Patient History Continued

Urinary

- ___ Frequent Urination
- ___ Painful Urination
- ___ Difficulty holding/starting stream
- ___ Kidney disease

Reproductive

- ___ Birth Control Method _____
- ___ Gonorrhea;Syphilis;HIV _____
- ___ Breast lump/bump/mass
- ___ Breast Pain/tenderness
- ___ Dimples in breast
- ___ Other breast changes
- ___ Hysterectomy
- ___ *First Day of Last Menstrual Cycle*
- ___ Painful menstruation
- ___ OTHER _____

Skin/Hair/Nails

- ___ Skin Growths
- ___ Mole Changes
- ___ Skin Cancer
- ___ Nail Changes-colour/shape
- ___ Hair Changes-texture, etc

Implants

- ___ Breast Implants
- ___ Cardiac Pacemaker
  Date: _____
- ___ Penile Implant

Neurological

- ___ Headaches
- ___ Back of head/neck
- ___ Temples
- ___ Forehead/behind eyes
- ___ Dizziness/Fainting
- ___ Seizures
- ___ Change in sensation
- ___ Stroke
- ___ Unusual Weakness
- ___ Head Trauma

Musculoskeletal

- ___ Joint Stiffness
- ___ Joint Pain
- ___ Joint Swelling
- ___ Muscle Cramps
- ___ Neck Pain
- ___ Mid back Pain
- ___ Low back Pain
- ___ Sacroiliac Pain
- ___ Fractures
- ___ Sprains/Strains
- ___ Arm problem
- ___ Leg problem
- ___ Other _____

Psychological

- ___ Anxiety
- ___ Depression

Hospitalizations

Diet/Supplementation

- ___ Vegetarian
- ___ Special Diet
- ___ Multivitamin
- ___ Calcium/Magnesium/Zinc

Daily fluid intake (8 oz cups)

- Water _____
- Juice/Milk _____
- Coffee/Tea _____
- Dark Caffeinated Cola _____

Other Supplements

_____
_____
_____

FITNESS/HEALTH

How Would You Rate Your *Overall Health*

- ___ Below average
- ___ Average
- ___ Above Average

Strength/Endurance

- ___ Below average
- ___ Average
- ___ Above Average

Flexibility

- ___ Below average
- ___ Average
- ___ Above Average

Doctor Signature/Date: _____

Patient Signature _____ **Date:** _____