Ashbridge's
Health Centre

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Chiropractors and Acupuncture Practitioners
1522 Queen St. East, Toronto, ON M4L IE3 416-465-5575

Patient Health Record

Name: ______________________ Pronouns: __________ Date: ______________
Address: ______________________ City: __________ Postal Code: __________
Date of Birth (M/D/Y): __________ Age: ________ Gender: ________
Telephone: (home) __________ (business) __________ (cell/pager) __________
Please circle which telephone number where you would like us to contact you
Email address: ______________________
Marital Status: CL M S W D Partner/Spouse's name: ______________
Children (names & ages): __________ __________ __________
Occupation: ______________________
Extended Health Insurance Company: ______________ Telephone: __________
How did you hear about us? ______________________

Current Health Condition

Claim made against WSIB? __________ Car insurance? __________
Previous Chiropractic care: ______________________
Other Previous Therapies: ______________________
What is your major concern: ______________________
How long have you had this condition? ______________________
What activities relieve it? ______________________
Is the condition getting worse or better over time? ______________________
Is it constant or does it come and go? ______________________
Is this condition interfering with activities of daily life? ______________________
Other concerns: ______________________
Medication/Drugs taking: ______________________
Supplements/vitamins taking: ______________________
MD Name: ______________________ Last visit: __________
Last dental exam: ______________________

Past Health History

Do you smoke? ______ If so, how much and for how long? ______________________
Do you exercise? ______ How often/how long/what types? ______________________
Do you drink alcohol? ______ If so, how much? ______________________
How do you rate your diet? ______ How is your sleep? __________ # hours per night? ______
Previous accidents/falls: ______________________
Surgeries/Hospitalizations: ______________________
Conditions diagnosed with: ______________________
Conditions in family history: ______________________

The information I have provided is accurate and true to the best of my knowledge. I also understand that there may be a cancellation charge if 24-hour notice is not given.

Date: ______________ Signature: ______________________

Check any of the following conditions that you have had: Patient Name ______________________

Muscles
- ☐ neck pain
- ☐ lower back pain
- ☐ mid back pain
- ☐ upper back pain
- ☐ shoulders
- ☐ leg: left/right
- ☐ knee: left/right
- ☐ arm pain
- ☐ joint pain/stiffness
- ☐ walking problems
- ☐ scoliosis
- ☐ sciatica
- ☐ difficult chewing
- ☐ clicking jaw
- ☐ general stiffness
- ☐ other ______________

Gastro-intestinal
- ☐ poor/excessive appetite
- ☐ excessive thirst
- ☐ frequent nausea
- ☐ vomiting
- ☐ diarrhea/constipation
- ☐ hemorrhoids
- ☐ liver problems
- ☐ kidney problems
- ☐ gall bladder problems
- ☐ ulcer
- ☐ hernia
- ☐ weight trouble
- ☐ abdominal cramps
- ☐ gas/bloating after meals
- ☐ heartburn
- ☐ black/bloody stool
- ☐ colitis
- ☐ difficult digestion

Genito-urinary
- ☐ bladder trouble
- ☐ discoloured urine
- ☐ painful/excessive urination

Nervous System
- ☐ nervousness
- ☐ numbness
- ☐ paralysis
- ☐ dizziness
- ☐ fainting
- ☐ stress sweats
- ☐ convulsions/seizures
- ☐ cold/tingling extremities

General
- ☐ fatigue
- ☐ allergies
- ☐ loss of sleep
- ☐ fever
- ☐ headaches: type ________

Skin
- ☐ rashes
- ☐ skin condition: type ____
- ☐ bruise easily

CVR
- ☐ asthma
- ☐ chest pain
- ☐ short breath
- ☐ blood pressure problems
- ☐ irregular heartbeat
- ☐ heart problems
- ☐ lung problems/congestion
- ☐ varicose veins
- ☐ ankle swelling
- ☐ stroke
- ☐ chronic cough
- ☐ poor circulation
- ☐ phlebitis

EENT
- ☐ vision problems
- ☐ dental problems
- ☐ sore throat/earaches
- ☐ ringing in ears
- ☐ nose bleeds
- ☐ sinus problems
- ☐ contact lenses

Male/Female
- ☐ prostate problems
- ☐ sexual dysfunction
- ☐ menstrual irregularities
- ☐ vaginal pain/infections
- ☐ breast pain/lumps
- ☐ miscarriage
- ☐ therapeutic abortion
- ☐ gynecological surgery
- ☐ menopause
- ☐ caesarean section
- ☐ pregnancy

Infections
- ☐ hepatitis
- ☐ plantar warts
- ☐ herpes
- ☐ HIV/AIDS
- ☐ TB

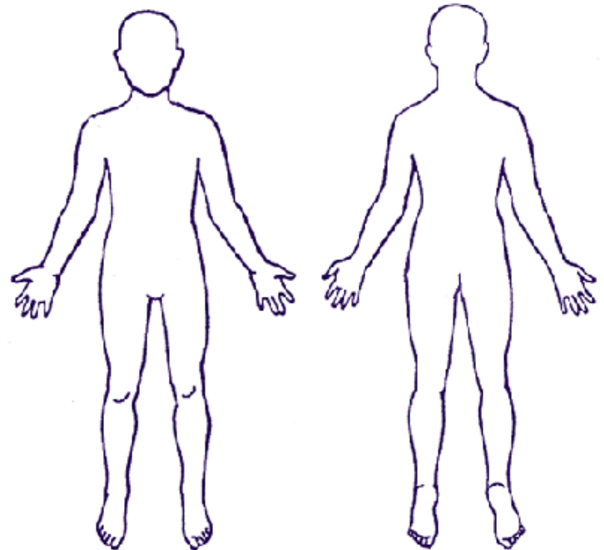
Diet Includes
- ☐ caffeine
- ☐ alcohol
- ☐ tobacco
- ☐ dairy products

Diseases
- ☐ pneumonia/pleurisy
- ☐ polio
- ☐ measles
- ☐ diabetes
- ☐ arthritis
- ☐ eczema
- ☐ anemia
- ☐ rheumatic fever
- ☐ whooping cough
- ☐ mumps
- ☐ chicken pox
- ☐ cancer
- ☐ epilepsy
- ☐ multiple sclerosis
- ☐ osteoporosis

Other Therapy
- ☐ chiropractic
- ☐ acupuncture
- ☐ naturopathic
- ☐ movement analysis
- ☐ craniosacral
- ☐ massage therapy
- ☐ shiatsu
- ☐ reflexology

Outline areas of discomfort on the diagram

AAA=aching | OOO=pins & needles | XXX=burning
*///=stabbing | ***=numbness*



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