VELLORE
CHIROPRACTIC
& WELLNESS CENTRE
9587 Weston Road, Unit 7, Woodbridge, ON

ADULT CHIROPRACTIC REGISTRATION FORM

Please take a few moments to complete both sides of this form.
The more information you provide us, the more we can help you!

LAST NAME: _____

FIRST NAME: _____

MIDDLE NAME (s):_____

NAME YOU PREFER TO BE CALLED: _____

SEX: □ Male □ Female BIRTHDATE (mm/dd/yyyy): _____/_____/_____

□ Single □ Married □ Separated □ Divorced □ Widowed □ Minor

OCCUPATION: _____

HOW DID YOU HEAR ABOUT US?
□ Phonebook □ Google □ Our website

□ Facebook □ Referred by: _____

□ Other: _____

ADDRESS: _____

CITY: _____ POSTAL CODE:_____

HOME: (____)_____ CELL: (____)_____

WORK: (____)_____ Preferred no. for us to call: _____

Best time of day to reach you: _____

E-mail Address: _____

Would you like an email reminder for appointments? □ YES □ NO
The reminder will be sent at 8:00am the day before your appointment.

We also use your email to keep in touch via a monthly newsletter. These newsletters contain updates on important changes at the office, such as holiday hours, new services, and promotions.
Please indicate if you would *not* like to receive these emails:
□ NO, don't send me any newsletters.

CONSULTATION HISTORY

Your main concern: _____

Any other concern: _____

How long have you suffered with this? _____

What makes it better temporarily? _____What makes it worse? _____

Which best describes the pain? □ Achy □ Sharp/Shooting □ Electric □ Stabbing □ Throbbing □ Other _____

What is the pattern of this problem? □ Constant □ Intermittent □ Occasional □ Cyclic

Does the pain… □ Stay where it is □ Travels or radiates to _____

Please mark with an "x" your level of discomfort.
I feel great |——————————————————| Worst pain imaginable

What have you tried to do to get rid of this problem that **DID NOT** work? _____

_____

What does this problem interfere with **OR** prevent you from doing? _____

_____

Please list any medications, prescription or over the counter, that you are taking : _____

PLEASE TURN PAGE OVER

ADULT CONSULTATION HISTORY...continued…

All of the following can impact how you respond to chiropractic care.

Please place a mark in the box if you experience, or have experienced, any of the following.

PHYSICAL STRESS

- □ Traumatic birth
- □ Slip/fall
- □ Poor posture
- □ Car accident
- □ Sports injury
- □ Work injury
- □ Physical abuse
- □ Sit on wallet
- □ Stomach sleeper
- □ Computer work
- □ Repetitive lifting/bending
- □ Prolonged driving
- □ Prolonged standing
- □ Prolonged sitting
- □ Surgery/broken bones
- □ Other _____

EMOTIONAL STRESS

- □ Relationships
- □ Career
- □ Family
- □ Money
- □ Fast paced life
- □ Hold in feelings
- □ Quick tempered
- □ Perfectionist
- □ Procrastinator
- □ Loss of loved one
- □ Feeling burned out
- □ Constantly worried
- □ Anxious
- □ Pessimistic
- □ Overscheduled
- □ Other _____

CHEMICAL STRESS

- □ Live(d) in new house
- □ Live(d) in large city
- □ Smoker
- □ Second hand smoke
- □ Caffeine
- □ Artificial sweeteners
- □ Prescription drugs
- □ Recreational drugs
- □ Self Medicate
- □ Poor diet
- □ Consume alcohol
- □ Fast food, more than 1x/mo
- □ Consumption of sugar
- □ Overeat or large portions
- □ Consume soda or fruit drinks
- □ Other _____

- □ Weight train ___x/week
- □ Cardio exercise ___x/wk
- □ Good posture
- □ Massage Therapy ____x/____mo
- □ Pilates
- □ Wear proper footwear/orthotics
- □ At proper body weight
- □ Yoga
- □ Other _____

- □ Meditate/prayer
- □ Take vacation/holidays
- □ Practice other stress reduction
- □ Take time for hobbies
- □ Social activities
- □ Optimistic
- □ Enough/quality sleep
- □ Attend spiritual service
- □ Other _____

- □ See a naturopath
- □ See other health practitioner
- □ Eat organic food
- □ Eat 5-12 fruits/vegs per day
- □ Eat 6 small meals/day
- □ Drink 8 glasses water/day
- □ Avoid processed foods
- □ Take vitamins/supplements
- □ Other _____

FOR OFFICE USE ONLY

P_____ E_____ C_____

PT_____/_____

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if there is a change in my health.
By signing this form, I consent to a chiropractic examination.

SIGNATURE: _____ **DATE:** _____