MMD CHIROPRACTIC HEALTH CENTRE
866 KING ST. W, HAMILTON, ON
L8S 1K3, 905.529.2911

PATIENT REGISTRATION

DATE:__________________
EMAIL:______________________________

SURNAME:		DATE OF BIRTH:	(D/M/Y) / /
FIRST NAME:		SEX:	☐ M ☐ F
ADDRESS:		FAMILY DOCTOR:	
		TELEPHONE#:	
POSTAL CODE:		CONTACT NAME:	
TELEPHONE #:		RELATION TO YOU:	
EMPLOYER:		TELEPHONE:	
OCCUPATION:		EXTENDED HEALTH CARE:	
MARITAL STATUS		POLICY #:	

HOW DID YOU HEAR ABOUT US: ☐ PATIENT ☐ FRIEND ☐ DOCTOR ☐ ADVERTISEMENT ☐ OTHER. PLEASE SPECIFY (NAME OF PERSON/PLACE) ____

ARE YOU PRESENTING FOR TREATMENT FOR AN INJURY , WELLNESS CARE OR BOTH ? (PLEASE CIRCLE)

ARE YOUR SYMPTOMS THE RESULT OF A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

ARE YOUR SYMPTOMS THE RESULT OF A WORK RELATED INJURY? ☐ YES ☐ NO

PAST CHIROPRACTIC CARE

HAVE YOU EVER BEEN TO A CHIROPRACTOR BEFORE? ☐ YES ☐ NO

IF YES, NAME OF CHIROPRACTOR SEEN: ______________________________ DATE LAST SEEN:______________

HAVE YOU HAD X-RAYS TAKEN OF THE AREA OF COMPLAINT PREVIOUSLY? ☐ YES ☐ NO

IF YES, WHAT WERE THE RESULTS: ____

HEALTH HISTORY

ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITION? ☐ YES ☐ NO, IF YES PLEASE LIST:

____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS/SUPPLEMENTS? ☐ YES ☐ NO, IF YES PLEASE LIST:

____

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO, PLEASE LIST: ____

____

LIST ANY SURGICAL PROCEDURES YOU HAVE RECEIVED: ____

____

PLEASE CHECK OFF THE APPROPRIATE BOXES THAT APPLY TO YOUR FAMILY MEDICAL HISTORY AND YOUR MEDICAL HISTORY:

FAMILY HISTORY					
CANCER	☐ YES ☐ NO		ARM PAIN	☐ YES ☐ NO	
STROKE	☐ YES ☐ NO		LEG PAIN	☐ YES ☐ NO	
DIABETES	☐ YES ☐ NO		FRACTURES	☐ YES ☐ NO	
HYPERTENSION	☐ YES ☐ NO		SPRAIN/STRAIN	☐ YES ☐ NO	
THYROID DISEAS	☐ YES ☐ NO		DISLOCATIONS	☐ YES ☐ NO	
OTHER, LIST			HEADACHES	☐ YES ☐ NO	
YOUR HISTORY			DIZZINESS	☐ YES ☐ NO	
ANEURYSM	☐ YES ☐ NO		NUMBNESS	☐ YES ☐ NO	
STROKE	☐ YES ☐ NO		FATIGUE	☐ YES ☐ NO	
EPILEPSY	☐ YES ☐ NO		THYROID DISEASE	☐ YES ☐ NO	
HEART CONDITIO	☐ YES ☐ NO		HIV POSITIVE	☐ YES ☐ NO	
OSTEOPOROSIS	☐ YES ☐ NO		PREGNANCY	☐ YES ☐ NO	
DIABETES	☐ YES ☐ NO		BIRTH CONTROL	☐ YES ☐ NO	
CANCER	☐ YES ☐ NO		PILLS	☐ YES ☐ NO	
HIGH/LOW BP	☐ YES ☐ NO		OTHER		
BONE DISEASE	☐ YES ☐ NO				
JOINT STIFFNESS	☐ YES ☐ NO		DO YOU DRINK		
MUSCLE CRAMPS	☐ YES ☐ NO		ALCOHOL?	☐ YES ☐ NO	
ARTHRITIS	☐ YES ☐ NO		DO YOU SMOKE?	☐ YES ☐ NO	
NECK PAIN	☐ YES ☐ NO				
BACK PAIN	☐ YES ☐ NO				

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Chief Complaint:

Please describe the reason for your visit to our office today?

____
____
____
____
____
____
____

Using the diagram below and the symbols provided, please indicate the location and the type of pain you are experiencing:

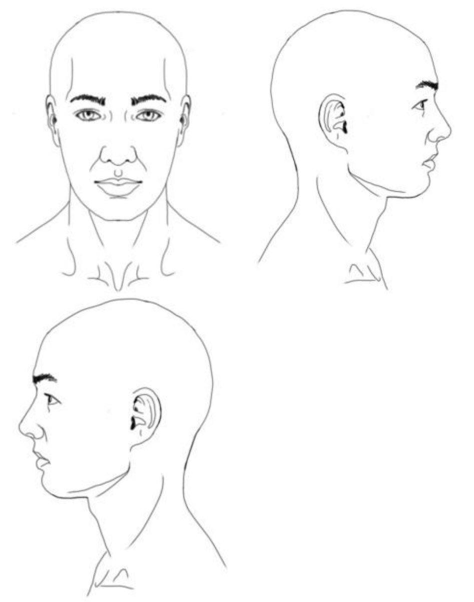
ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
^^^^^	=======	oooooooo	....	/ / / / / / / / /	XXXXX

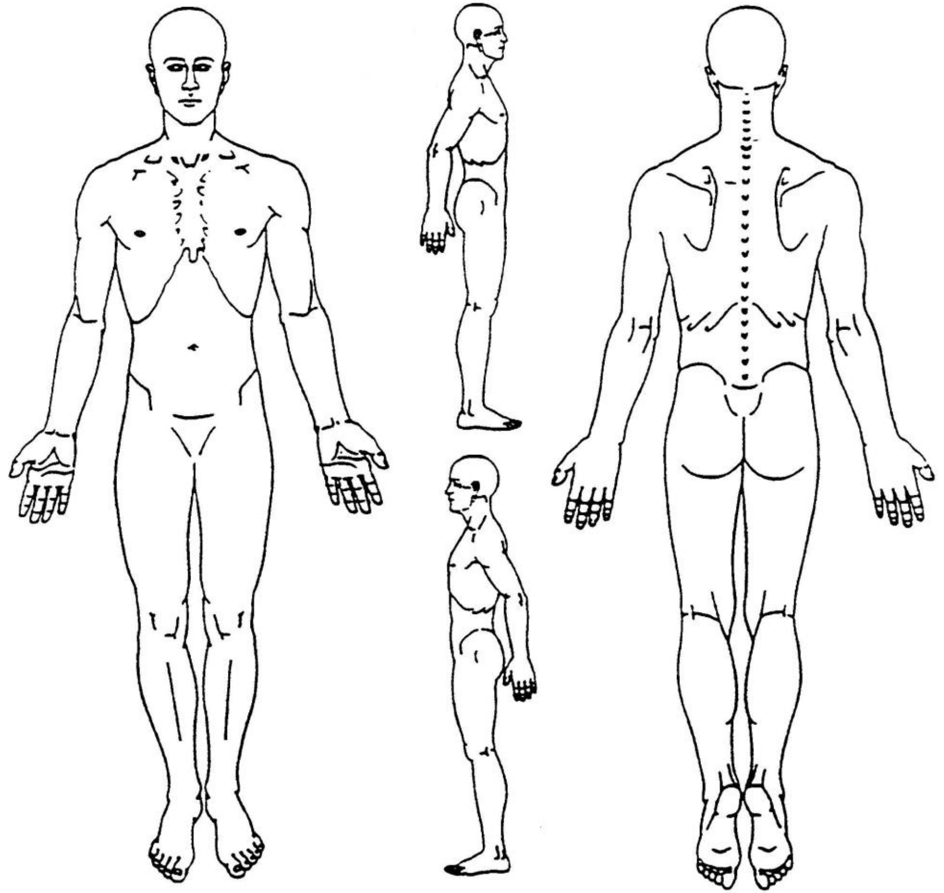
When did your symptoms start?

- ☐ 0-3 months ago
- ☐ 3-6 months ago
- ☐ 6-9 months ago
- ☐ 1 year ago

Indicate what makes your Symptoms better or worse

	Better	Worse
Sitting	☐	☐
Standing	☐	☐
Bending forward	☐	☐
Bending backward	☐	☐
Movement/activity	☐	☐
Lying down	☐	☐
inactivity	☐	☐





Please indicate the level of pain you are experiencing: **No pain 1 2 3 4 5 6 7 8 9 10 Worst pain ever**