ADVANCED HEALTHCARE

CONFIDENTIAL NEW PATIENT INFORMATION
Welcome to our office! Please complete all questions…

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PERSONAL HISTORY: **Today's Date: (D)** ____ **/ (M)** _____ **/ (Y)** _____

Name: _____ Pronoun: _____ Address: _____

City: _____ Province: ____ Postal Code: _____ **Health Card #:** _____ **Ver #:** ____

Home Tel #: ( ) _____ Birth Date: (D) ____ / (M) _____ / (Y) _____ Age: ____ Sex: _____

Cell Tel #: ( ) _____ Email: _____ Last MD physical exam date: _____

Do you have Extended Health Coverage? ☐ Not Sure ☐ No ☐ If yes, with whom? _____

Business/Employer**:** _____ Occupation: _____

Business Tel #: ( ) _____ Marital Status: (Circle One) M S W D CL (Common-Law)
☐ ☐ ☐ ☐ ☐

Children's names and ages:

1. _____ Age _____ 3. _____ Age _____
2. _____ Age _____ 4. _____ Age _____

Who can we thank for referring you to us: _____ **Tel #: ( )** _____

YOUR CURRENT HEALTH CONDITION(S): Height:_____ **Weight:**_____ **Shoe Size:**_____ **(Reg - W - N)**

List your **top 3** current health complaints in order of priority**: (Other complaints, please advise Dr. Pisarek)**

1. _____ When & how did it start? _____
2. _____ When & how did it start? _____
3. _____ When & how did it start? _____

How would resolving or improving your complaint(s) with Dr. Pisarek impact your life?

_____

_____

Have these conditions occurred before? ☐ No ☐ Yes Please explain: _____

Is it getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes & Goes ☐ Other: _____

Pain character: ☐ Sharp ☐ Dull ☐ Tight / Stiff ☐ Achy ☐ Burning ☐ Throbbing ☐ Numb ☐ Pins and Needles

Rate your overall pain level on a scale of 1 to 10 (10 being the highest): _____. Please describe how it feels when this problem is at its worst: _____

What aggravates your condition(s)? ☐ Sitting ☐ Walking ☐ Standing ☐ Lying down ☐ Bending ☐ Lifting ☐ Running ☐ Jumping ☐ Cold ☐ Heat ☐ Rain ☐ Dampness ☐ Other _____

What relieves your condition(s)? ☐ Chiropractic Adjustments ☐ Nothing ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Stretching ☐ Exercise ☐ Ice ☐ Heat ☐ Massage ☐ Medication ☐ Rubs ☐ Physio Other_____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: ____ /10.

Medications, Vitamins, Herbal Remedies you now take:_____

Have you had X-rays taken in the past six months? ☐ No ☐ Yes, where? _____

PAST HEALTH HISTORY: (Please check and/or describe)

Major Surgery / Operations: ☐ Cancer ☐ Stroke ☐ Heart Attack ☐ Brain ☐ Gall Bladder ☐ Hernia ☐ Fractures ☐ Joint Sprains / Strains ☐ Appendectomy ☐ Tonsillectomy ☐ Other: _____

Auto Accidents, Slips, Trips, Falls: _____

Hospitalizations (other than above): _____

Previous Chiropractic Care: ☐ None ☐ If yes, when was your last chiropractic adjustment: _____

Do you presently or in the past smoke(d): Tobacco/Cannabis/Vape products ☐ Yes ☐ No Used: THC/CBD ☐ Yes ☐ No

(PLEASE TURN OVER)

The following list includes issues that might not seem related to your visit today. However, it is important to answer these questions thoughtfully, as they could impact your overall chiropractic care plan.

PLEASE CHECK ANY OF THE CONDITIONS BELOW THAT YOU HAVE EXPERIENCED IN THE PAST SIX (6) MONTHS, OR THAT HAVE BEEN ONGOING FOR A SIGNIFICANT PERIOD IN YOUR LIFE…

MUSCULO-SKELETAL:
- ☐ Neck Pain ☐ Shoulder Pain
- ☐ Arm Pain ☐ Elbow Pain
- ☐ Wrist Pain ☐ Hand Pain
- ☐ Mid-Back ☐ Low-Back Pain ☐ Leg Pain
- ☐ Hip - Knee - Ankle - Foot Pain (Circle)
- ☐ Jaw (TMJ) Pain ☐ Chewing Problems
- ☐ Arthritis ☐ Spinal Disc Problems

NERVOUS SYSTEM:
- ☐ Headaches ☐ Concussion
- ☐ Numbness ☐ Paralysis
- ☐ Vertigo ☐ BPPV
- ☐ Dizziness ☐ Tinnitus (Ear Noise)
- ☐ Fainting ☐ Meniere's Disease
- ☐ Confusion ☐ Memory Problems
- ☐ Convulsions ☐ Epilepsy ☐ Anger Prob.
- ☐ Stress ☐ Nervous ☐ PTSD ☐ Anxiety
- ☐ Depression ☐ Crying / Yelling Outbursts
- ☐ Extremities: ☐ Cold ☐ Numb ☐ Tingling

GENERAL:
- ☐ Fatigue ☐ Energy: ☐ Low ☐ High
- ☐ Allergies?_____
- ☐ Loss of Sleep ☐ Nightmares
- ☐ Fever ☐ Gas ☐ Bloating After Meals
- ☐ Passing Excessive Gas
- ☐ Poor Diet ☐ Bad Eating Habits
- ☐ Problems with: ☐ Getting Up ☐ Sitting ☐ Standing ☐ Walking ☐ Running ☐ Jumping ☐ Bending ☐ Twisting ☐ Squatting

GENITO-URINARY:
- ☐ Bladder Trouble
- ☐ Urination: ☐ Painful &/or ☐ Excessive
- ☐ Bloody Urine ☐ Discoloured ☐ Cloudy

CARDIO-VASCULAR:
- ☐ Stroke History ☐ Heart Attack
- ☐ Chest Pain ☐ Heart Problems
- ☐ Irregular Heartbeat ☐ Snoring
- ☐ Blood Pressure: ☐ Low ☐ High
- ☐ Asthma ☐ Shortness of Breath
- ☐ Lung Problems ☐ I Smoke
- ☐ I use a CPAP Machine ☐ Yes ☐ No
- ☐ Varicose Veins ☐ Ankle Swelling

EYES-EARS-NOSE-THROAT:
- ☐ Vision Problems ☐ I Wear Glasses
- ☐ Eye Cataracts ☐ Dental Problems
- ☐ Sore Throat / Coughing / Swallow prob.
- ☐ Earaches ☐ Hearing Difficulty
- ☐ I Wear Hearing Aids: ☐ Yes ☐ No
- ☐ Stuffy Nose ☐ Sinus Problems

DO YOU HAVE A REGULAR EXERCISE PROGRAM?
- ☐ No ☐ If yes, describe: _____
- _____
- _____

GASTRO-INTESTINAL:
- ☐ Poor Appetite ☐ Excessive Appetite
- ☐ Eating Disorder ☐ Excessive Thirst
- ☐ Frequent Nausea ☐ Indigestion
- ☐ Vomiting ☐ Vomit with Blood
- ☐ Diarrhea ☐ Colitis ☐ Heartburn
- ☐ Constipation ☐ Stool: Bloody / Black
- ☐ Abdominal Cramps ☐ Hungry Often
- ☐ Liver Problems ☐ Hemorrhoids
- ☐ Gall Bladder Problems
- ☐ Weight Problem: ☐ Gain ☐ Loss
- ☐ I Consume Alcohol

FEMALES ONLY:
When was your last period?
(D) ___ (M) _____ (Y) _____.
Are You Pregnant?
☐ Yes ☐ No ☐ Not Sure

FEMALE / MALE PROBLEMS:
- ☐ Fibromyalgia Disorder
- ☐ Menstrual Irregularity / ☐ Cramping
- ☐ Vaginal Pain ☐ Vaginal Infections
- ☐ Breast Pain ☐ Breast Lumps
- ☐ Frequent Urination
- ☐ Sexual Dysfunction
- ☐ Prostate Problems

LIFESTYLE STRESS LEVEL:
☐ High ☐ Moderate ☐ Minimal

☐ Diabetes? Please describe: _____

☐ Cancer? Please describe: _____

HEREDITARY (GENETIC) DISEASES: ☐ No ☐ Not Sure ☐ Yes, please describe: _____

_____

Why Chiropractic? People seek chiropractic care for a variety of reasons. Some come looking for relief from pain or discomfort—this is known as 'Relief Care'. Others aim to address not only their symptoms but also the underlying cause of the issue—referred to as 'Corrective Care'. Then there are those who pursue care to enhance overall body function and maintain optimal health—this is called 'Preventive Care'. These three (3) stages represent the phases of chiropractic care. If you choose to move forward, Dr. Pisarek will consider your specific needs and goals when creating a personalized care plan. His recommendations will include elements from all three phases and will be thoroughly discussed with you during your private 'results' visit.

Please check the type of care desired so that Dr. Pisarek may be guided by your wishes whenever possible:

☐ **Preventative Care** ☐ **Corrective Care** ☐ **Relief Care** ☐ **I want all three (3) previous types of care!**

☐ **Check here if you want Dr. Pisarek to select the best type of care appropriate for your complaints and health.**

PLEASE READ CAREFULLY: I understand and agree that health and accident insurance policies are agreements between the insurance carrier and myself. The team at Dr. Pisarek's office will make every effort to prepare any required reports and forms to assist in facilitating reimbursement from my insurance company. Any authorized payments made directly to Dr. Pisarek will be credited to my account once received. I also acknowledge that all services provided are billed directly to me, and I am fully responsible for settling my account with Dr. Pisarek. Finally, I give permission for Advanced Healthcare, Dr. Pisarek, and their staff to communicate with me electronically via telephone, fax, or the internet as needed.

PATIENT / GUARDIAN SIGNATURE: _____ Date: (M) _____ (D) _____ (Y) _____.