



Welcome Back Spinal Care Centre

4915 Bathurst St., Suite 230, Toronto, ON M2R 1X9 (416) 512-2225

Confidential Patient Case History

Date _____

Name _____ Address _____

City _____ Province _____ Postal Code _____

Birthdate (m/d/y) ____/____/____ Age _____ Sex M / F Marital Status S / M / D / W

Phone No. Home _____ Work _____ Cell _____

Occupation _____ Email _____

How did you hear about our office? _____

What other forms of treatment have you had? (Please rate the results achieved – 5-Excellent to 1-Poor)

- | | | | | | | |
|--|--|---|---|---|---|---|
| <input type="checkbox"/> Chiropractic | | 5 | 4 | 3 | 2 | 1 |
| <input type="checkbox"/> Medical: Medication | | 5 | 4 | 3 | 2 | 1 |
| <input type="checkbox"/> Medical: Surgery (type _____) | | 5 | 4 | 3 | 2 | 1 |
| <input type="checkbox"/> Physiotherapy | | 5 | 4 | 3 | 2 | 1 |
| <input type="checkbox"/> Massage Therapy | | 5 | 4 | 3 | 2 | 1 |
| <input type="checkbox"/> Acupuncture | | 5 | 4 | 3 | 2 | 1 |
| <input type="checkbox"/> Other _____ | | 5 | 4 | 3 | 2 | 1 |

Health Issues - Please list all current conditions and any medications you are taking:

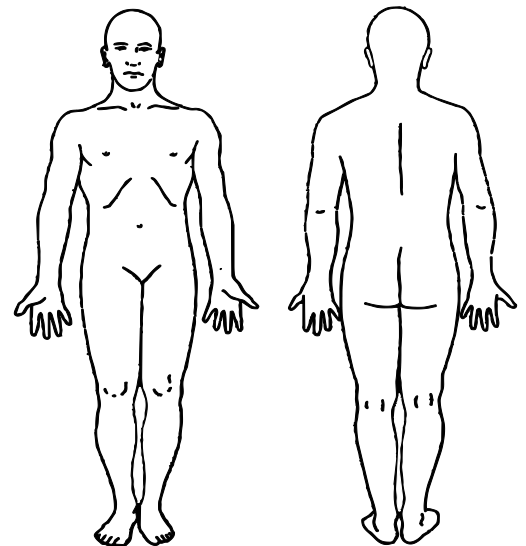
Where is your pain and, if applicable, where does it travel?
(Please indicate on the diagram to the right)

How long have you had the pain overall? _____

Was the onset: sudden / gradual / associated with an event

What was the cause _____

How long have you had this episode? _____



What is the pattern of pain?

Constant / Intermittent / Occasional / Cyclical

If the pain is **constant**, does it get better and worse? Y N

If the pain is **not constant**, how often do you get the pain? _____ per dy / wk / mth / yr (circle one)

How long does the pain last per incident? _____

When you are in pain, how long does it last?

Without medication _____ With medication _____

Describe the pain _____
(sharp, achy, dull, burning etc.)

Do you get numbness or tingling? Y N If yes, where? _____

Do you get weakness? Y N If yes, where? _____

What, if anything, aggravates the pain? _____

Do you get pain with: (circle all that apply) sneezing / coughing / laughing / going to bathroom

What, if anything, relieves the pain? _____

In what sports, exercise routine or recreational activity do you normally partake:

Other information: (for office use)