Core wellness centre - HEALTH HISTORY FORM ___

Today's Date: _____ Who may we thank for this referral? _____

First Name: _____ Last Name: _____ Preferred First Name:_____

Street Address: _____

City:_____ Province:_____ Postal Code:_____

Home phone:_____ Cellular:_____ Work:_____

Age:_____ Gender:_____ Birthdate: (D)_____ (M)_____ (Y)_____ Pregnant: Y / N

Marital Status: _____ Spouse Name:_____

# of Children:_____ their names and ages:_____

Occupation: _____ Employer: _____

Primary Email: _____

INSURANCE

Insurance Provider: _____Group/Policy#:_____Member ID#:_____Spouse DOB:_____

Have you been in a car accident in the last 12 months ? Yes/No If yes: Accident Date: _____

CHIROPRACTIC/PHYSIO HISTORY

Have you been to a chiro/physio before? Yes/No Name of previous chiro/physio: _____

How long were you under care? _____ What were the results?_____

THE PURPOSE OF MY VISIT

- ❑ Symptom relief and preventing its return.
- ❑ 100% optimum health and wellbeing on every level available to me.
- ❑ My commitment level to optimal health is (please rate from 0 to 10) : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

MEDICAL INFORMATION

Please check any of the following conditions currently or recently experienced:

- ❑ Neck Pain
- ❑ Headaches
- ❑ TMJ
- ❑ Hearing / Ear Problems: Left / Right
- ❑ Thyroid Problems:Underactive / Overactive
- ❑ Blood Pressure Problems: Low / High
- ❑ Numbness in arms/hands
- ❑ Shoulder Pain: Left / Right
- ❑ Arm Pain: Left / Right
- ❑ Hand/Wrist Pain: Left / Right
- ❑ Recurrent colds/flu
- ❑ Dizziness
- ❑ Allergies/Hay fever: _____
- ❑ Tingling in arms/hands
- ❑ Weakness in grip
- ❑ Low energy/fatigue
- ❑ Mid back/Shoulder blade pain
- ❑ Asthma/Wheezing
- ❑ Pain w/deep breath/expiration
- ❑ Nausea
- ❑ Indigestion/Heartburn/Acid Reflux
- ❑ Tired/Irritable w/out eating
- ❑ Recurrent lung infections/bronchitis
- ❑ Shortness of breath
- ❑ Heart attack/Angina
- ❑ Rib/Chest Pain: Left / Right
- ❑ Heart palpitations
- ❑ Ulcers/Gastritis
- ❑ Low back pain
- ❑ Numbness in legs/feet
- ❑ Frequent/difficulty urinating
- ❑ Muscle cramps in legs/feet
- ❑ Weight Problems
- ❑ Pain/Injury Knee Pain: Left / Right
- ❑ Pain/Injury Ankle Pain: Left / Right
- ❑ Carpal Tunnel Syndrome: Left / Right
- ❑ Gallbladder Problems
- ❑ Kidney Problems
- ❑ Immune Function Problems
- ❑ Chronic Fatigue/Fibromyalgia
- ❑ Skin Problems
- ❑ Prostate Problems
- ❑ Gout Disc Herniation
- ❑ Arthritis
- ❑ Fertility Problems
- ❑ Sexual Functioning Problems
- ❑ Diarrhea
- ❑ Liver Problems
- ❑ Stomach / Digestive Problems
- ❑ Sleeping Problems
- ❑ Anxiety
- ❑ Constipation:_____
- ❑ Hot Flashes
- ❑ Depression
- ❑ Alcohol / Substance Challenges
- ❑ Menstrual irregularities/cramping
- ❑ High Cholesterol
- ❑ Heart Problems:_____
- ❑ Stroke
- ❑ Diabetes: Type 1 / Type 2
- ❑ Aids/ HIV
- ❑ Multiple Sclerosis
- ❑ Weak in legs/feet
- ❑ Sciatica: Left / Right
- ❑ Recurrent Infections:

__ Ear __ Sore Throat
__ Respiratory/Colds
__ Bladder Infections
__ Yeast Infections

- ❑ Family History: diabetes / cancer / heart disease / other family related illness
- ❑ Other conditions:_____

Name:_____ **Date:**_____

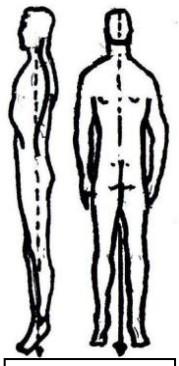
MAJOR HEALTH CONCERNS: Please identify 3 major health concerns you are currently experiencing.
On a scale of **0** to **10,** with **zero** being no pain and **10** being the worst pain, rate your concerns by ***circling the number*** **:**

Problem # 1_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem begin? _____ How did the problem begin? _____
Is it : ❑ Getting better ❑ Getting worse ❑ Staying the same
Pains are : ❑ Dull ❑Ache ❑ Tightness ❑ Throbbing ❑ Spasm ❑ Numb ❑ Sharp ❑ Burning ❑ Shooting
How long does it last ? ❑ It's constant ❑ I experience it on and off during the day ❑ It comes and goes through the week
What activities aggravate this problem ? Please describe: _____
Is there anything that relieves your symptoms ? ❑ No ❑ If yes, please describe: _____

Problem # 2_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem begin? _____ How did the problem begin? _____
Is it : ❑ Getting better ❑ Getting worse ❑ Staying the same
Pains are : ❑ Sharp ❑ Dull ❑Ache ❑ Burning ❑ Tightness ❑ Throbbing ❑ Spasm ❑ Numb ❑ Shooting
How long does it last ? ❑ It's constant ❑ I experience it on and off during the day ❑ It comes and goes through the week
What activities aggravate this problem ? Please describe: _____
Is there anything that relieves your symptoms ? ❑ No ❑ If yes, please describe:

Problem # 3_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem begin? _____ How did the problem begin? _____
Is it : ❑ Getting better ❑ Getting worse ❑ Staying the same
Pains are : ❑ Sharp ❑ Dull ❑Ache ❑ Burning ❑ Tightness ❑ Throbbing ❑ Spasm ❑ Numb ❑ Shooting
How long does it last ? ❑ It's constant ❑ I experience it on and off during the day ❑ It comes and goes through the week
What activities aggravate this problem ? Please describe: _____
Is there anything that relieves your symptoms ? ❑ No ❑ If yes, please describe: _____

OFFICE USE ONLY



C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
S1
C

Kemp's
C/S + -
L/S + -

Weight
_____

Rx Meds :

Sx :

Fx :

MVA's :

Work Related Injuries :

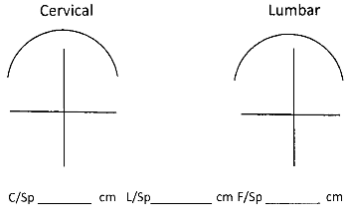
Sports / Rec Injuries :

Injuries at Home :

Injuries at Birth / Childhood :

Patient's body signals for conditions checked off in Medical History section :

Chief:
Other:
Most imp:
Length / differ:
Trauma/MVA/Work:
Tried:
Feel like:
1-10:
Prevent:
S/B/W – freq/inten:
Corrected:
Desire:



Clinical Implications / Dx
__VSC CTLS
__Assoc Muscle Dysfunction
__Advanced Arthritis
__Other: _____
__Acute / mod / chron sprain/strain _____

Prognosis – expected outcome
__excellent; good; fair; poor
Other_____

Consent
__Verbal Consent to Exam

Plan of Managements
__Corrective Adjustments
__Spinal Exercise
__Nutritional
__Other_____
__2x / 24v
__1x / 24v
__2x/__v; 1x/___v; 1x/2wk__v

Dr. Kris Dorken - Core Wellness Centre / 726 St. Clair Ave W.. Toronto. ON M6C 1B3 / Tel: 416-479-8311 / www.corewellnesscentre.ca

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Updated: September 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____ _____ _____
Patient/Guardian Signature Date Chiropractor Signature