Ajax Family Chiropractic ● 145 Kingston Road East, Unit 13 ● Ajax, Ontario, L1S 7J4 ● (905) 426-4116
www.ajaxfamilychiro.com Dr. Michael Gauthier Dr. Mark Kasiban Dr. Robbie Berman

First Name	Family Name		Date
Address	City		Postal Code
Date of Birth (M) (D) (Y)	Age:	Gender:	Email:
Home Phone:	Work:		Cell:
OK to contacted me at: ❒ Home ❒ Work ❒ Cell ❒ Email OK to leave a message at: ❒ Home ❒ Work OK to text? ❒ YES ❒ NO			Emergency Contact Name: Number:
Have you ever received Chiropractic care before? ❒ YES ❒ NO If YES, When & Why:			Physician: Occupation:

WHY THIS INFORMATION IS IMPORTANT

At **Ajax Family Chiropractic** we focus on creating healthy families. Our goal is to understand the reason(s) that brought you to our office and to offer you and your family an opportunity to improve your overall health through chiropractic care (a wellness lifestyle). Stress is a major cause of poor health. Stress can overwhelm your body and can alter your ability to adapt to your environment. Stress on the body may occur suddenly or gradually, it may be harsh or subtle --- the effects are cumulative. Physical stress can come from physical trauma, injuries, or from regular activities. Chemical stress comes from the environment, from what you eat, and even your medications. Emotional stress is life in general, like dealing with family, work, or school on a daily basis. By answering the following questions, you will give us a profile of the stress(es) you have faced in your lifetime. Understanding your challenges helps us identify what is limiting your ability to heal and your ability to express your true health potential. Let's figure it out and find solutions together.

WHAT BRINGS YOU TO OUR OFFICE?

Did **someone suggest our Office** to you? ❒ YES ❒ NO, If YES, name _____

If not, **how did you hear about us**? ❒ Facebook ❒ Website ❒ Internet Search ❒ Online Ad ❒ Advertising ❒ Lives Nearby ❒ Family/Friend ❒ Doctor ❒ Other: _____

What is your **main reason(s)** for consulting our Office? _____

_____ _____ _____

Have you received **previous care** for your **main reason(s)**? ❒ YES ❒ NO

what type of care?_____

What are **your long-term health goals**? _____

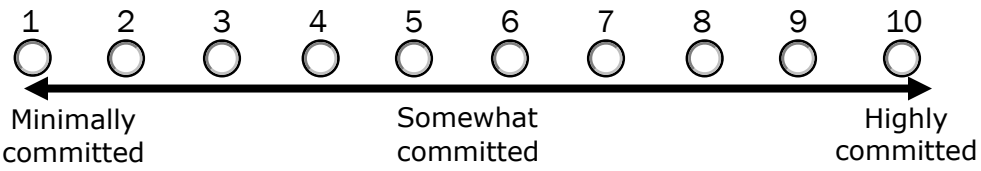
What is your main reason for wanting to get better/be healthier?

(e.g. enjoy time with family, live longer, live easier, get back to work, can't cope with it, it is just the right time?)

_____

_____

On a scale of 1 to 10 (10 being the highest), rate your commitment to improving your health *(check a number)*



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YOUR HEALTH/STRESS PROFILE

Did you:	**as a: Child**	**Teenager**	**Adult**	**None**
Play contact sports	❒	❒	❒	❒
Have any serious falls or traumas	❒	❒	❒	❒
Get involved in any car accidents	❒	❒	❒	❒
Have any work injuries	❒	❒	❒	❒
Have any surgeries/hospitalizations	❒	❒	❒	❒
Use medication for extended periods	❒	❒	❒	❒
Use street drugs for extended periods		❒	❒	❒
Drink alcohol		❒	❒	❒
Smoke cigarettes		❒	❒	❒

on a scale from 1 - 10
describe your **stress level**
(1 – None / 10 – Extreme)

Personal: _____

Educational: _____

Occupational: _____

YOUR MEDICAL HEALTH PROFILE

Do you suffer from:

Mind problems such as: ❒ headaches ❒ sleep disturbance ❒ depression ❒ anxiety
❒ fainting ❒ dizziness ❒ balance problems ❒ **NONE**

Body problems involving: ❒ heart, circulation or blood ❒ eyes or ears ❒ joints or bones
❒ digestion or stomach ❒ sinuses, nose or throat ❒ muscles or ligaments
❒ bowel or bladder ❒ breathing, chest or lungs ❒ foot or ankle ❒ **NONE**

Conditions such as: ❒ skin infections/irritations ❒ allergies ❒ diabetes ❒ hepatitis ❒ cancer ❒ HIV ❒ **NONE**

List **any other medical condition(s)** which we should know about? _____

YOUR CURRENT LIFESTYLE PROFILE

Personal Satisfaction with Diet? ❒ Highly Satisfied ❒ Satisfied ❒ Unsatisfied ❒ Highly Unsatisfied

Do you drink water regularly? ❒ YES ❒ NO, how much? _____

Do you exercise regularly? ❒ YES ❒ NO, If YES how often? _____

what type(s) of exercises? _____

Do you take any vitamins, supplements or natural products? ❒ YES ❒ NO,

If Yes, Please list: _____

Do you take medication on a regular basis? ❒ YES ❒ NO, If Yes Please list:

Over the counter: _____ Prescription(s):_____

_____ _____

YOUR FAMILY'S HEALTH PROFILE

At our Office we focus on your health and well-being, as well as the health and well-being of your family and loved ones. Please list the names, ages, and any health condition(s) or concerns your family members may have:

Name, age, condition/concern(s)	**Name, age, condition/concern(s)**
Spouse	Mother
Children	Father
	Siblings

I verify the information provided is true and accurate to the best of my knowledge. I understand I am responsible for the cost of my care and payment is due at the time of service. By signing below, I consent to a complete health history and comprehensive chiropractic examination (including a radiographic examination if deemed necessary by the doctor).

Typed Signature: _____ Date:_____ Dr.'s Initials: _____

We recognize that quality health care is based on a mutual understanding between you and your doctor.
We invite you to ask any questions you may have regarding your care.