



Dr. Anita Rajan, DC
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Patient Intake Form

Last name	Middle Initial	First name	Male / Female
Address	City	Province	Postal Code
Date of Birth (Day/Month/Year)	Current Age	Marital Status	# of Children
Email address	Occupation	Employer	Hours per day
Home Phone	Cell Phone	Work Phone	
Emergency Contact Name	Phone	Relationship	

Ok to contact via email or to leave phone messages regarding my care at the above numbers Y / N

Family Physician Name	Phone	Address
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Permission to consult as clinically indicated? Y / N

Patient Signature (Legal Guardian if under age 18)	Date
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How did you discover our office and the professional health care services we offer? _____

Your Health Concerns or Symptoms

What is your main health concern or condition that you would like to improve? _____

What caused this condition and when did it begin? _____

Please describe the current condition. _____

What aggravates the condition? _____

What relieves the condition? Please list all therapies/activities that are helping. _____

Please rate your pain/discomfort on a scale of 0 (none)-10 (extreme): / 10

Is the condition getting worse, please explain? Y N _____

Does the condition interfere with: Work Y N _____
Daily Life Y N _____
Sleep Y N _____

Has there been a medical diagnosis? What is the diagnosis? _____

Have you had: X-rays Y N Date performed and area: _____
CT scan Y N Date performed and area: _____
MRI Imaging Y N Date performed and area: _____
Ultrasound Y N Date performed and area: _____

Do you have any internal pins, wires/artificial joints? If so, please indicate location. _____

Please list any medications (prescription and over-the-counter) that you are currently taking. _____

Please list any vitamins, herbs, nutritional supplements you take regularly. _____

Describe the exercise activities you do, including frequency. _____

Please list dates and descriptions of any accidents, injuries, surgeries and hospitalizations. _____

Describe your typical diet: Breakfast- Lunch- Dinner- _____

Do you feel healthy? Y N _____

Have you ever been in for Chiropractic care before? Y N When? _____

What is an aspect of your life that very much pleases you, brings you joy, and helps you to feel balanced? _____

Family History

Please check if any of your family members have or ever had any of the following conditions:

	Relation
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> High Cholesterol	_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform Dr. Anita Rajan of any changes to my health.

Patient Name (Print) Patient Signature (Legal Guardian if under 18 yrs) Date

Health History

Please check the box beside any symptoms you are presently experiencing and underline any conditions you have experienced in the past. Please add details.

General

- Fever/chills
- Night sweats
- Weight loss/gain
- Loss of sleep
- Loss of appetite
- Clumsiness

Musculoskeletal

- Headaches
- Neck pain
- Mid back pain
- Low back pain
- Hip pain
- Knee pain
- Ankle/Foot pain
- Shoulder pain
- Elbow pain
- Wrist/Hand pain
- Jaw/TMJ pain
- Tendonitis
- Bursitis
- Arthritis
- Joint stiffness/swelling
- Spasms/Cramps
- Fractured Bones
- Osteoporosis/Osteopenia
- Scoliosis
- Fibromyalgia
- Other

Skin

- Rashes/Hives
- Allergies
- Warts
- Moles
- Acne
- Cosmetic Surgery
- Sensitive/Dry
- Herpes/Cold sores
- Other

Cardiovascular

- Heart Disease
- High Blood pressure
- Low Blood pressure
- High Cholesterol
- Stroke
- Angina
- Dizziness/Fainting
- Cold feet/hands
- Swollen ankles/edema
- Varicose veins
- Blood clots
- Shortness of breath

Respiratory

- Sinus problems
- Asthma
- Allergies
- Emphysema
- Bronchitis/Pneumonia
- Cough
- Smoking

Digestive

- Indigestion
- Stomach pain
- Ulcer
- Nausea
- Vomiting
- Bloating
- Constipation
- Diarrhea
- Gall bladder/appendix
- Hiatal/Inguinal hernia
- Crohn's
- Ulcerative colitis
- Irritable Bowel Syndrome
- Diverticulitis
- Other

Immune system

- Colds/Flu often
- HIV/AIDS
- Lymphedema
- Allergies
- Other

Systemic conditions

- Diabetes
- Cancer
- Hepatitis/Cirrhosis
- Tuberculosis
- Gout
- Hyper/Hypo Thyroid

Nervous system

- Numbness/Tingling
- Twitching
- Fatigue/Chronic pain
- Sleeping difficulty
- Paralysis
- Epilepsy
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease
- Spinal cord injury
- Confusion
- Blurry/Double vision
- Vision loss
- Hearing loss
- Ringing in ears
- Memory Loss/Forgetful

Genitourinary

- Urinary tract infection
- Painful urination
- Kidney/Bladder infection
- Kidney Stone
- Other

Reproductive system

Women

- Pregnancy
- PMS
- Menopause
- Irregular periods
- Fertility concerns
- Other

Men

- Prostate problems
- Other

Psychological

- Stress
- Emotional Crisis
- Depression
- Addictions:
- Psych Counseling

Other

- Alcohol
- Recreational Drugs
- Caffeine
- Nicotine

Surgeries/Hospitalizations

- _____
- _____

Therapies Used

- Chiropractic
- Massage therapy
- Naturopathy
- Homeopathy
- Aromatherapy
- Chinese medicine
- Acupuncture
- Ayurveda
- Yoga
- Osteopathy
- Physiotherapy
- Energy healing
- Reflexology

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatments. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques;

- b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present scientific and medical evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____ 20_____

Name of Patient (please print)

Name of Witness (please print)

Signature of Patient (or Legal Guardian)

Signature of Witness