JOHNSON CHIROPRACTIC CLINIC
102-130 Sproule Rd
Perth, ON ~ K7H 3C9
(613) 264-2402 ~ fax (613) 264-2410

PTL II Laser Intake

Patient # __________

Name: ____

Date of Birth dd _______/mm________/ yy________

Address: ____

____

(Please circle) Married Single Common Law Divorced Widowed

Phone: (home) ______________________________ Spouse's name: ____

(work) ______________________________ Do you have children? _________ How many? _________

Employer: _________________________________ Children's names ____________________________________

Your occupation: ___________________________ MD ____

Emergency Contact person: ___________________ Phone # ____

Have you ever received chiropractic care: yes no

If yes by whom: ____ When ____________________________________

How did you discover the Johnson Chiropractic Clinic? ____

Please describe your current problem, if any....

____

____

When did this problem start? (Specific date if possible)____

____

How often do you experience this condition?

□ Constant (76 -100%) □ Frequent (51 - 75%)

□ Occasional (26-50%) □ Intermittent (25% or less)

Is the condition worse in □ AM □ PM □ no difference

Is the condition interfering with □ sleep □ work □ routine □ recreation □ other

Please rate your condition. Circle a number (0 = no effect, 10 = unbearable)

0 1 2 3 4 5 6 7 8 9 10

Is condition getting progressively worse? □ Yes □ No □ Staying the same

What aggravates your condition?____

____

____

What relieves your condition?____

____

____

Have you had x-rays, CT Scans, or MRI's or ultrasound taken ? □ yes □ no

If yes.... when ______________________ Where ______________________

List any and all medication you are currently taking:

____

Please list any herbs, nutritional supplements or natural home remedies you take regularly: ______________________

List any surgeries and include when? ______________________

Is there a family history of: (✓ all that apply)

	Heart Disease	**Stroke**	**Cancer**	**Arthritis**	**Diabetes**	**Other**
Mother	□	□	□	□	□	□ ________
Father	□	□	□	□	□	□ ________
Brother(s)	□	□	□	□	□	□ ________
Sister(s)	□	□	□	□	□	□ ________

Do you use: □ coffee □ tea □ artificial sweeteners

□ alcohol □ cigarettes □ recreational drugs

How would you rate your health: (circle the number that best describes how you are feeling)

Yuk...I've never felt worse Wow I feel great!

1 2 3 4 5 6 7 8 9 10

How committed are you to improving your health:

Nah, not important I want to be 100% healthy

1 2 3 4 5 6 7 8 9 10

What is being healthy to you (✓ all that apply)?

□ Not being sick □ Being symptom free

□ Having energy to do what I want, when I want □ Not needing to take time off work

□ To fully enjoy all aspects of life to the fullest extent possible

What do you hope to do better and enjoy more as a result of the improved health you will gain from cold laser therapy?

____

Email: ______________________

I give **express consent** to Johnson Chiropractic Clinic for email contact such as birthday greetings, to notify me of special offers, events & our newsletter. I can withdraw my consent at any time. This consent does not apply to statements, reminders or appointments lists, these notifications are covered under implied consent and do not need express consent.

______________________ ______________________

Patient's signature *Date*

(If you are completing this online please complete the Wellness Check)

PATIENT ALLERGY/SENSITIVITY SURVEY

Check any of these you believe may be causing you any problems:

□ Shell Fish
□ Wine, Beer, Alcohol
□ Fruits / Berries, Nuts
□ Bed Wetting
□ Eggs, Grains
□ Animal Dander, Feathers, Fur
□ Nightshades (tomatoes, potatoes, peppers)
□ Fabrics, Upholstery, Plastics
□ Skin issues, Acne, Eczema, Psoriasis
□ Laundry Detergents, Softeners
□ Dairy (milk, cheese, yogurt, etc.)
□ Asthma, Breathing issues
□ Lack of Energy
□ Sleep Issues
□ Coffee, Chocolate, Tea, (caffeine)
□ Anxiety/Stress issues
□ Perfumes, Candles, Oils, Shampoo, Makeup
□ Nutritional Supplements/Herbal Remedies
□ Environmental (pollen, grass, Trees, mold)
□ Metals ______________________________
□ Stinging Insects
□ Seasonal Allergies
□ Focus, Concentration, Memory Issues
□ Emotional Upset/Traumas____________
□ Chemicals, Latex____________________
□ Other ______________________________
□ Digestive Issues, Bloating, Gas,
□ Performance Issues_________________

Please answer the following questions about the above substances:
Which of the above causes you the most trouble? ________________________________
____

On the 1-10 scale below, how would you rate your discomfort from this allergy/sensitivity, when it's at its worst?
Mild 1 2 3 4 5 6 7 8 9 10 **Severe**

How long have you been suffering with this allergy/sensitivity problem?
_____weeks _____months _____years

How does this allergy/sensitivity condition affect your ability to perform daily tasks (check one)
□ No major impact – I get along fine
□ It bothers me – but I just carry on
□ It bothers me – slows me down, sometimes
□ It's an occasional problem – but when it's bad, it's really bad
□ It bothers me all the time – it can stop me from doing things I want to do
□ I'm desperate – I need help

Would you like to eliminate or reduce this allergy/sensitivity this problem? □ Yes □ No
If you Smoke, would you like to quit? □ Yes □ No
If Yes, Why?____________________________________

We offer an advanced program to reduce or eliminate many of the allergies and sensitivity issues you and/or your family members may be experiencing.
Please let us know if you would like to receive more information.