

## **Recommendations to New Patients**

During your initial visit to our office, you will receive a physical examination and a diagnostic examination. Your diagnostic examination will include a bilateral skin temperature scan, and/or a stress analysis.

**In order to obtain the most accurate diagnostic results, please follow these simple instructions:**

### ***Proper Attire***

- Indoor shoes (no flip flops)
- Comfortable loose clothing
- Remove all jewelry from the neck up ie: necklaces, ear rings, facial piercing
- Bring a clip or elastic if you have long hair

***Pain Medications:*** No pain medications for 4 hours prior to your chiropractic visit.

***Caffeine Drinks:*** No coffee, tea, chocolate, pop...caffeine free drinks are approved.

***Alcohol:*** No alcohol for 4 hours prior to your chiropractic visit.

***Smoking:*** No smoking for 1 hour prior to your chiropractic visit.

# INTAKE FORM

James A. Aldridge, D.C.

Minal Gandhi, D.C.

13-322 Argyle St. S., Caledonia, ON N3W 1K8

T: 905-765-4025 F: 905-765-4026

**Patient:**

**Patient Number:**

**Flag:**

## Box #1: General Information

Date of Birth d/m/y      Sex: M/F      Who may we thank for referring you to our office?

Primary reason for consulting our office:

Any other associated warning signs or complaints?

How long has this been going on? Days: \_\_\_\_\_ Months: \_\_\_\_\_ Years: \_\_\_\_\_

Any previous incidents in your life?

## Box #2: Personal Information

Address		City	Postal Code
Hm Phone	Fax	Email	
Employer	Address		Occupation
Wk Phone	Cell	Pager	Fax:
May we call you at any of these numbers? Y N			
Do you have XHC (insurance) coverage for chiropractic care? Y N Particulars:			
When did you last have chiropractic care?	Who?	# of visits	
X-rays in the last two years? Y N	Area X-rayed	Where are the x-rays located?	
Family Doctor	Others seen for this condition		
Marital Status: Single ___ Married ___ Common Law ___ Separated ___ Divorced ___ Widow ___ Widower ___	Name: _____ # of Children: _____		

## Box #3: Visits Scheduled

Visit1: \_\_\_\_\_ Time: \_\_\_\_\_ Visit 2: \_\_\_\_\_ Time: \_\_\_\_\_

# YOUR LIFE REVIEW

Patient Name: \_\_\_\_\_ M F Number: \_\_\_\_\_

## Current Health Challenge Information

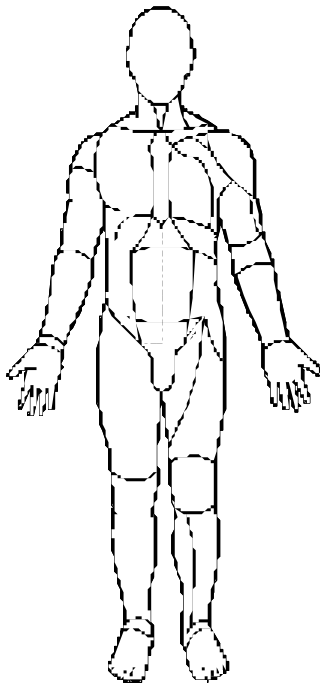
- Describe the pain:** sharp dull travels constant  
**Since the onset, is the pain:** worse better the same on & off  
**What makes it worse:** standing sitting lying motion other  
**What relieves it:** standing sitting lying motion other  
**Does the pain cause you to:** lose sleep be short tempered miss work miss play  
lose focus  
**Are any of your systems involved:** digestive cardiovascular respiratory elimination  
reproductive  
**Are you a smoker:**  Yes  No

**Any other facts about your current condition:** \_\_\_\_\_

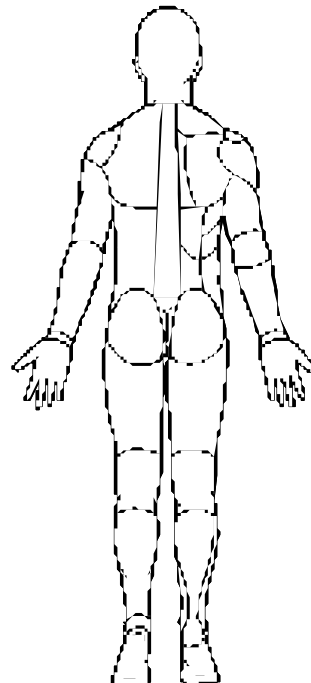
**Place an X on the graph indicating the severity of your condition:** Least ①②③④⑤⑥⑦⑧⑨⑩ Worst

**Please mark on the diagram your areas of concern:**

**FRONT**



**BACK**



**List current medications and when last taken:** \_\_\_\_\_

**James A. Aldridge, D.C.**  
13-322 Argyle St. S., Caledonia, ON N3W 1K8

**Minal Gandhi, D.C.**  
T: 905-765-4025 F: 905-765-4026

**Patient Name:** \_\_\_\_\_ **M F** **Number:** \_\_\_\_\_

**INJURY HISTORY**

Do you play sports?  Yes  No What sports? \_\_\_\_\_

Have you ever broken a bone?  Yes  No Which ones? \_\_\_\_\_

Have you ever been knocked out?  Yes  No

Have you ever been in a motor vehicle accident? (please note type and year, even if not apparently injured)

List all surgeries and dates: \_\_\_\_\_

**Things I currently do to support my health include:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Drink plenty of water     | <input type="checkbox"/> Alcohol in moderation | <input type="checkbox"/> Maintain the proper weight  |
| <input type="checkbox"/> Exercise regularly        | <input type="checkbox"/> Get plenty of rest    | <input type="checkbox"/> Maintain positive attitude  |
| <input type="checkbox"/> Counseling/therapy        | <input type="checkbox"/> Annual Physical Exams | <input type="checkbox"/> Self-improvement books      |
| <input type="checkbox"/> Orthotics/heal lifts      | <input type="checkbox"/> Pray/meditate         | <input type="checkbox"/> Eat organically grown foods |
| <input type="checkbox"/> Use a cervical pillow     | <input type="checkbox"/> Yoga/Pilates/Aerobics | <input type="checkbox"/> Vitamins, minerals or herbs |
| <input type="checkbox"/> Attend religious services | <input type="checkbox"/> _____                 |  |

**Please check the appropriate box for any of the following symptoms which you now have or have had previously.**

**O = Occasional      F=Frequent      C= Constant**

<p><b>O   F   C</b></p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> frequent colds <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cold hands/feet <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bowel problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> restless sleep <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nervousness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> high blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> tight muscles <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> accelerated aging <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> heart palpations <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> poor expressions of emotion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> anxiety <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ulcers	<p><b>O   F   C</b></p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ADD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hypoglycemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> poor concentration <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cognitive worry <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> irritability <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> impulsivity <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> distraction <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> low energy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> disorganization <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> incontinence <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> muddledness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> poor awakening <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> low pain threshold	<p><b>O   F   C</b></p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> headaches <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> narcolepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sleep walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pre Menstral Syn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hot flashes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> allergies <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bipolar disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> eating disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bed wetting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mood swings <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> panic attacks <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____
---	---	--

<p><b>O   F   C</b></p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> fevers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> epstein-barr syndr	<p><b>O   F   C</b></p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> fibromyalgia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> depression <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> rheumatoid arthritis	<p><b>O   F   C</b></p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> chronic fatigue <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> auto-immune disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> fatigue
---	---	--