1960 Appleby Line, Suite 25, 2nd Floor, Burlington, ON
(905) 332-7447

Dr. Tom Lopac B.Sc., D.C., F.I.C.P.A., CMAG

CHIROPRACTIC

Personal History

Name ____ Date _____________________________

Address ____

City ________________________ Prov. __________________ Postal Code ________________________

Phone: Day _________________ Evening ________________ Mobile ____________________________

E-Mail ____

Age __________ Date of Birth: Month _______ Day_____ Year______ (mmmddyyyy)

Marital Status ______________________ Occupation ____

Name & ages of children (under age 25) ____

How did you hear about or office?____

Previous Chiropractor's Name ______________________________ Last Visit _______________________

Name of Medical Doctor ______________________________ Phone ____________________________

Health History

What is your major complaint? ____

How long Have you had this condition ? ____

What do you do that makes this problem worse / better? ______________________________________

____

Is this condition interfering with your: __ Work __ Sleep __ Daily Routine

Other Complaints? ____

____

On a scale from 1 to 10, with 10 being the worst and 1 being the least, rate your pain

1 2 3 4 5 6 7 8 9 10

Please list any Surgical Operations ____

Drugs you are currently taking ____

Other Medication(s) ____

Vitamins / Supplements ____

Have you ever been in an Auto Accident? Yes __ No __(if Yes?) How many? __ Date _______________

Have you had any other Personal injuries ____

or Work Injuries ____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatmet Plan and possibility of being accepted for care.

CHECK THE BOX BESIDE ANY OF THE FOLLOWING YOU HAVE HAD

	Appendicitis		Malaria		Chicken Pox		Alcoholism		Pneumonia
	Scarlet Fever		Tuberculosis		Diabetes		Venereal Infection		Measles
	Diphtheria		Whooping Cough		Cancer		Arthritis		Goiter
	Typhoid Fever		Anemia		Heart Disease		Epilepsy		Mental Disorder
	Rheumatic Fever		Mumps		Influenza		Lumbago		Polio
	Small Pox		Pleurisy		Eczema		Fibromyalgia		

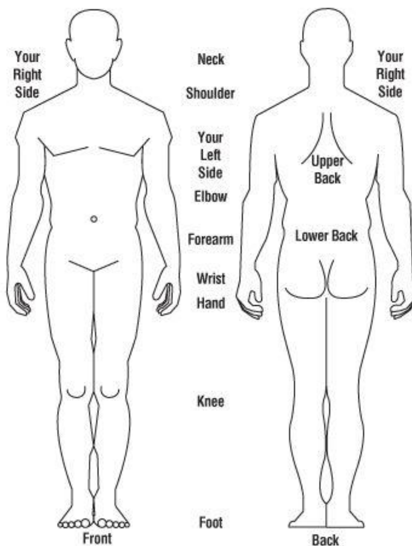
CHECK ANY OF THE FOLLOWING YOU HAVE or HAVE HAD IN THE PAST FEW MONTHS

	MUSCULO-SKELETAL CODE		NERVOUS SYSTEM CODE				GENERAL CODE		GENITO-URINARY CODE
	Low Back Pain		Numbness		Fainting		Allergies		Bladder Trouble
	Pain Between Shoulders		Paralysis		Convulsions		Loss of Sleep		Painful/Excessive Urination
	Neck Pain		Dizziness		Cold/Tingling Extremities		Fever		
	Leg Pain		Forgetfulness				Headaches		
	Difficult Chewing		Confusion				Migraines		
	Clicking Jaw		Depression				Allergies		

	GASTRO-INTESTINAL CODE						C-V-R CODE		
	Poor/Excessive Appetite		Constipation		Black/Bloody Stool		Chest Pain		Varicose Veins
	Excessive Thirst		Hemorrhoids		Colitis		Short Breath		Ankle Swelling
	Frequent Nausea		Liver Trouble		Heart Burn		Blood Pressure Problems		
	Vomiting		Gall Bladder Trouble				Irregular Heartbeat		
	Diarrhea		Weight Changes				Heart Problems		
	Gas/Bloating After Meals		Abdominal Cramps				Lung Problems/Congestion		

	EENT CODE		MALE/FEMALE CODE	FEMALES ONLY
	Vision Problems		Menstrual Irregularity	When was your last period:
	Dental Problems		Menstrual Cramping	Are You Pregnant? Yes No Maybe
	Sore Throat		Vaginal Pain/ Infections	
	Ear Aches		Breast Pain/Lumps	
	Hearing Difficulty		Prostate/Sexual Dysfunction	
	Stuffed Nose		Genital Herpes	

Please Outline in the diagram the area of your Discomfort



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FAMILY HEALTH HISTORY

Patient Name: ____ Date:_________________

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation C (current) or P (past) under his or her column to indicate the problem. Leave blank those spaces that do no apply. If you require more space, use the reverse side of this form.

Condition	**Father Age __**	**Mother Age ___**	**Spouse Age __**	**Sister(s) Age __ __**	**Brother(s) Age __ __**	**Children Age __ __**
Arthritis						
Asthma / Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Emotional Problems						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraines						
Nervousness						
Neuritis						
Pinched Nerves						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other						