Dr. Ailin Oishi-Stamatiou / 924 Eglinton Ave.East, Toronto, ON M4G 2L3 / 416-425-9730 / www.droishi.com

PATIENT ENTRANCE FORM

Name_____ Date_____

Address_____

City, Province_____ Postal Code_____

Home Tel._____ Cell_____

Bus. Tel._____E-mail_____

Date of Birth (D/M/Y)_____ Age_____ Gender: Male / Female

Marital Status – S M D W S Spouse's Name_____

Children_____

Emergency Contact_____ Phone_____

Occupation (Your)_____

Employer_____Bus. No._____

Address_____

City, Province_____ Postal Code_____

Extended Health Care Company_____

How did you hear about our office: _____

CLAIM WILL BE MADE AGAINST:

1. Recent motor vehicle accident: Yes / No (if yes see attached)
2. Work related injury/accident: Yes / No (if yes see attached)

PRIOR CHIROPRACTIC CARE:

Name_____ Telephone_____

Address_____

Date of last appointment_____Reason for visit_____

MEDICAL DOCTOR:

Name_____ Telephone_____

Address_____

Date of last appointment_____Reason for visit_____

X-rays / US / MRI / CT / results_____

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Reason for consulting this office: _____

_____

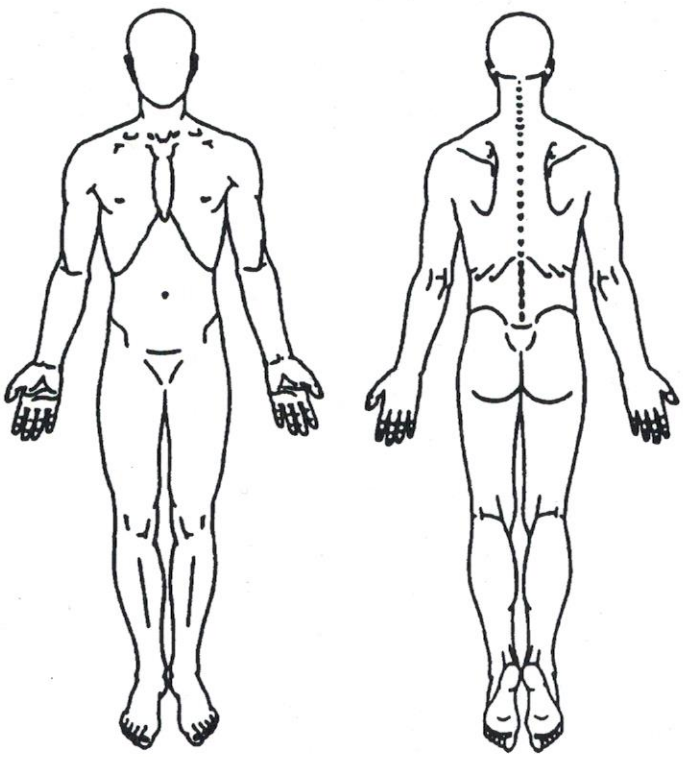
_____

Expectations: _____

Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.



Numbness • • • • •
• • • • •
• • • • •

Pins & Needles 0 0 0 0 0
0 0 0 0 0
0 0 0 0 0

Burning X X X X X
X X X X X
X X X X X

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /
/ / / / /

Have you ever had any of the following:

aneurysm _____ osteoporosis _____ diabetes _____ arthritis _____

respiratory conditions _____ epilepsy _____ cancer _____

strokes _____ allergies _____ heart conditions _____

hepatitis _____ "nerves" _____ fatigue _____ polio _____

sleeping difficulty _____ pneumonia _____ pleurisy _____

asthma _____ V.D. _____ psoriasis _____ HIV _____

sinus conditions _____

Childhood conditions had, please check:

- ❑ measles
- ❑ mumps
- ❑ chicken pox
- ❑ whooping cough
- ❑ scarlet fever
- ❑ diphtheria
- ❑ rheumatic fever
- ❑ typhoid fever
- ❑ ear infections
- ❑ tubes in ears
- ❑ chronic ill

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PATIENT PAST HISTORY FORM

Name: _____ Date: _____

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

C = Constant F = Frequent O = Occasional

C F O

NEUROLOGICAL

- ❑ ❑ ❑ allergy
- ❑ ❑ ❑ chills
- ❑ ❑ ❑ convulsions
- ❑ ❑ ❑ dizziness
- ❑ ❑ ❑ fainting
- ❑ ❑ ❑ fevers
- ❑ ❑ ❑ headaches
- ❑ ❑ ❑ loss of sleep
- ❑ ❑ ❑ nervousness
- ❑ ❑ ❑ depression
- ❑ ❑ ❑ neuralgia
- ❑ ❑ ❑ numbness
- ❑ ❑ ❑ sweats
- ❑ ❑ ❑ loss of weight
- ❑ ❑ ❑ tremors

MUSCLE & JOINT

- ❑ ❑ ❑ arthritis
- ❑ ❑ ❑ bursitis
- ❑ ❑ ❑ foot trouble
- ❑ ❑ ❑ hernia
- ❑ ❑ ❑ low back pain
- ❑ ❑ ❑ neck pain
- ❑ ❑ ❑ neck stiffness
- ❑ ❑ ❑ pain between shoulders

RESPIRATORY

- ❑ ❑ ❑ chest pain
- ❑ ❑ ❑ chronic cough
- ❑ ❑ ❑ difficulty breathing
- ❑ ❑ ❑ spitting blood
- ❑ ❑ ❑ throat phlegm
- ❑ ❑ ❑ wheezing

EYES, EARS, NOSE & THROAT

- ❑ ❑ ❑ colds
- ❑ ❑ ❑ crossed eyes
- ❑ ❑ ❑ deafness
- ❑ ❑ ❑ dental decay
- ❑ ❑ ❑ asthma
- ❑ ❑ ❑ ear aches
- ❑ ❑ ❑ ear discharges
- ❑ ❑ ❑ ear noises

C F O

- ❑ ❑ ❑ sinus infections
- ❑ ❑ ❑ enlarged glands
- ❑ ❑ ❑ enlarged thyroid
- ❑ ❑ ❑ sore throat
- ❑ ❑ ❑ tonsillitis
- ❑ ❑ ❑ eye pain
- ❑ ❑ ❑ failing vision
- ❑ ❑ ❑ far sighted
- ❑ ❑ ❑ gum trouble
- ❑ ❑ ❑ hay fever
- ❑ ❑ ❑ hoarseness
- ❑ ❑ ❑ nasal obstruction
- ❑ ❑ ❑ near sighted
- ❑ ❑ ❑ nosebleeds

CARDIO-VASCULAR

- ❑ ❑ ❑ rapid heart beats
- ❑ ❑ ❑ slow heart beat
- ❑ ❑ ❑ swelling of ankles
- ❑ ❑ ❑ hardening of arteries
- ❑ ❑ ❑ high blood pressure
- ❑ ❑ ❑ low blood pressure
- ❑ ❑ ❑ pain over heart
- ❑ ❑ ❑ poor circulation

GASTRO INTESTINAL

- ❑ ❑ ❑ excessive hunger
- ❑ ❑ ❑ burping or gas
- ❑ ❑ ❑ liver trouble
- ❑ ❑ ❑ colitis
- ❑ ❑ ❑ colon trouble
- ❑ ❑ ❑ constipation
- ❑ ❑ ❑ diarrhea
- ❑ ❑ ❑ difficult digestion
- ❑ ❑ ❑ distension of abdomen
- ❑ ❑ ❑ stomach pain
- ❑ ❑ ❑ gall bladder trouble
- ❑ ❑ ❑ hemorrhoids
- ❑ ❑ ❑ intestinal worms
- ❑ ❑ ❑ jaundice
- ❑ ❑ ❑ poor appetite
- ❑ ❑ ❑ nausea
- ❑ ❑ ❑ vomiting
- ❑ ❑ ❑ vomit blood

C F O

SKIN

- ❑ ❑ ❑ boils
- ❑ ❑ ❑ bruise easily
- ❑ ❑ ❑ dryness
- ❑ ❑ ❑ hives or allergy
- ❑ ❑ ❑ itching
- ❑ ❑ ❑ skin rash
- ❑ ❑ ❑ varicose veins

GENITO-URINARY

- ❑ ❑ ❑ bet wetting
- ❑ ❑ ❑ blood in urine
- ❑ ❑ ❑ frequent urination
- ❑ ❑ ❑ loss control urine
- ❑ ❑ ❑ kidney infection
- ❑ ❑ ❑ painful urination
- ❑ ❑ ❑ prostate trouble
- ❑ ❑ ❑ pus in urine
- ❑ ❑ ❑ smell of urine

PAIN OR NUMBNESS IN:

- ❑ ❑ ❑ shoulders
- ❑ ❑ ❑ arms
- ❑ ❑ ❑ hands
- ❑ ❑ ❑ hips
- ❑ ❑ ❑ legs
- ❑ ❑ ❑ knees
- ❑ ❑ ❑ ankles
- ❑ ❑ ❑ feet
- ❑ ❑ ❑ painful tail bone
- ❑ ❑ ❑ sciatica
- ❑ ❑ ❑ swollen joints

FOR WOMEN ONLY

- ❑ ❑ ❑ cramps
- ❑ ❑ ❑ heavy flow
- ❑ ❑ ❑ light flow
- ❑ ❑ ❑ irregular cycle
- ❑ ❑ ❑ painful cycle
- ❑ ❑ ❑ discharge
- ❑ ❑ ❑ sore breasts

Menopausal: ❑ Yes ❑ No

Last menstration date:

_____

Pregnant: ❑ Yes ❑ No

due date: _____

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PATIENT PAST HISTORY FORM (continued)

HABITS OF LIFESTYLE:

Do you smoke: ❑ Yes ❑ No Do you consume alcohol: ❑ Yes ❑ No

Do you exercise: ❑ Yes ❑ No Exercise Indoor Activities:

Exercise Oudoor Activities: _____

Rate your sleep, hours per night: 4 - 6 6 - 8 8 - 10 12+

Do you wake rested: ❑ Yes ❑ No

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Do you eat per day: 1 meal 2 meals 3 meals 4 meals More than 4 meals

Date of last Dental Examination: _____

Falls and Accidents - list: _____

_____

Surgery and Operations - list: _____

_____

Surgery recommended but not performed, list: _____

_____

Do you take vitamins and minerals, list: ❑ Yes ❑ No

_____

Have you ever been knocked unconscious: ❑ Yes ❑ No ❑ Don't know

If so, for how long: _____

List any medication or drugs you are currently taking: _____

_____

_____

Have you previously been hospitalized: ❑ Yes ❑ No

Please list: _____

Any family health conditions or problems: ❑ Yes ❑ No

Please list: _____

Signature: _____ Date: _____