BALANCE FAMILY CHIROPRACTIC

Dr. Jennifer Murray
102-12840 Yonge Street, Oak Ridges, ON L4E-4H1 905.773.5165

Welcome to Balance Family Chiropractic. To help us serve you better, please provide us with the following information. Please note, there are 2 PAGES to this form!! We look forward to working with you.

Patient Name: _____ Date:_____
Address: _____ City: _____ Province: ___
Postal Code: _____ Home Phone #: _____
Alternate #: _____ Birth Date (day/month/year) ___/___/___ Gender: Male Female
Who May We Thank for Referring You?_____
Names of Parents / Guardians: _____

Purpose For Contacting Us? _____

Check any of the Following Conditions you have suffered from during the past six months:

□ Ear Infections□ Scoliosis	□ Seizures	□ Chronic Colds	
□ Asthma	□ Digestive Problems	□ ADHD	□ Recurring Fevers
□ Allergies	□ Bed Wetting	□ Car Accident	□ Headaches
□ Autism	□ Growing Pains	□ Back pain	

□ Other _____

Does your condition interfere with:
Sleeping? □ Yes □ No Daily Activities? □ Yes □ No Exercising? □ Yes □ No

When did you first notice this condition? _____

Were you ever knocked unconscious? □ No □ Yes Comments: _____

Have you broken any bones? □ No □ Yes Comments: _____

Previous Chiropractic Experience? □ No □ Yes Name of Chiropractor _____
Date of last visit : ___/___/___
Name of Family Doctor : _____
Date of last visit: ___/___/___ Reason : _____

Number of Doses of Antibiotics taken:
During the past six months : _____ Total during lifetime : _____

Number of Doses and type of Other Prescription Medications taken:
During the past six months : _____
Total during lifetime: _____
Vaccination History: _____

Are you involved in any high impact or contact type sports (ie. Soccer, Football, Gymnastics, Baseball, Ballet, Martial Arts, etc…) □ No □ Yes List: _____

I exercise: ____ times a week.
Type of activity? _____

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PATIENT NAME:

_____

Have you ever been involved in a car accident? □ No □ Yes List: _____

Have you ever been seen on an emergency basis? □ No □ Yes List: _____
Have you ever been hospitalized? □ No □ Yes List: _____
What was actually done to you?_____

Other traumas (falls, accidents, injuries) not described above? □ No □ Yes
List: _____

Prior Surgery? □ No □ Yes List: _____
Menarche (Female Cycle Start) ? □ No □ Yes Age: ___

Birth History (for parent to fill out)
Complications during pregnancy? □ No □ Yes List _____

Medications during pregnancy/delivery? □ No □ Yes List: _____

Birth Intervention : ___ Forceps ___ Vacuum Extraction ___ Caesarian Section, Emergency or Planned (please circle)
Complications During Delivery? □ No □ Yes List _____

Genetic Disorders or Disabilities? □ No □ Yes List _____

Have you had: a spinal tap ___ spinal injections ___ physiotherapy___ neck collar ___ spinal brace ___ heel lift ___ corrective shoes or bars on shoes ___ bone in a case or immobilized ___ naturopathy ___ homeopathy ___

Have you ever had X-rays done before? □ No □ Yes When?_____

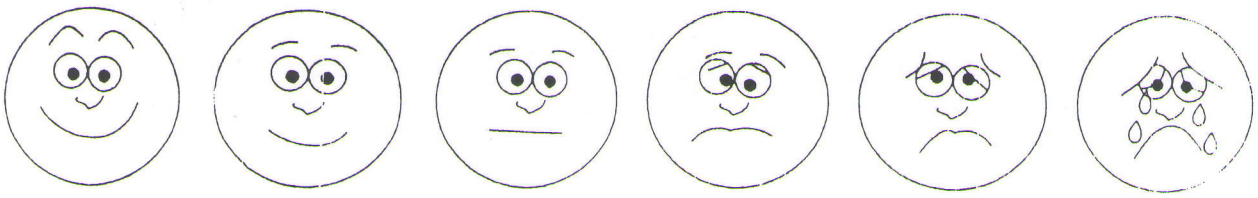
I give my consent for Dr. Jennifer Murray or her designate to perform a full and comprehensive examination on my child which may include case history, thermal scan, posture analysis, x-ray and hands on chiropractic spinal exam. I clearly understand and agree that I am personally responsible for payment of all fees charged by Balance Family Chiropractic. I understand that my personal information will be kept confidential in accordance with the privacy legislation.

_____ _____
Signature of Parent Date

Faces and Visual Analog Pain Scales

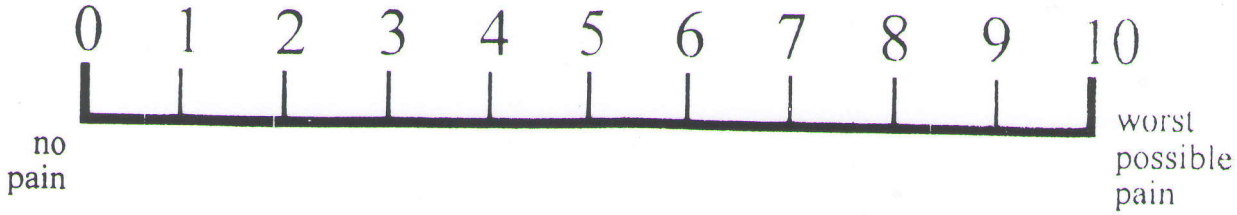
Please circle the number and/or the face that best refers to your level of pain (or lack thereof!) today. Please sign and date.

Faces Pain Scale



0	2	4	6	8	10
Very happy, no hurt	Hurts just a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts as much as you can imagine (don't have to be crying to feel this much pain)

Visual Analog Scale (VAS)



Date: _____

Signature: _____