Dr. Douglas Vlaskamp, D.C., Clinic Director, Chiropractor, Laser Therapist
Dr. Rishi Tayal, D.C., Chiropractor, Laser Therapist, Spinal Decompression Specialist
118 Queen St. West, Suite 205, Brampton, ON, L6X 1A5 905-451-3963

New Patient Form (Child) - Chiropactic & Low Intensity Laser Therapy

PERSONAL INFORMATION

Last Name:_____ First Name:_____

Birth Date: _____ /_____ / _____ / Age: _____ Gender: Male/Female
DAY MONTH YEAR

Address:_____

City:_____ Province:_____ Postal Code:_____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____

Email address: _____

How would you like to be reminded of appointments? Home____ Cell ___ Work___ Email___

How did you hear about us? Family___ Friend ___ Internet ___ Doctor ___ Advertising ___

EMERGENCY CONTACT

Last Name:_____ First Name:_____

Relationship: Parent____ Relative ___ Friend___

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____

CONSENT TO BE EXAMINED BY THE CHIROPRACTOR

I consent to be examined by the chiropractor to help with my treatment. Examination may consist of range of motion tests, orthopedic tests, and hands on assessment of joint mobility and/or muscle tension or weakness. The Chiropractor will explain the steps of the examination. I understand that I may withdraw consent at any point and will let the Chiropractor know if I do not want him to proceed with the examination. Date: _____

PATIENT NAME:_____ PATIENT SIGNATURE: _____
PLEASE PRINT OR PARENT/GUARDIAN IF UNDER THE AGE OF 16

DC'S NAME:_____DR. DOUGLAS VLASKAMP / DR. RISHI TAYAL_____ DC'S SIGNATURE: _____

CHIEF COMPLAINT – HISTORY OF PRESENT ILLNESS

Why are you here today?_____

Body area(s) involved: Neck___ Back___ Head___ Ribs___ Pelvis___ Upper Extremity___ Lower Extremity___

Is this condition: New___ Recurrence___ Exacerbation___ Chronic___

How did injury occur? Slip or Fall ___ Overexertion ___ Repetitive Use ___ Slept Wrong ___ No Injury ___

Is this injury: Auto Related___ (You will need to fill in additional forms)

Use the letters below to indicate TYPE and LOCATION of your sensations right now:

A=Aching

B=Burning

N=Numb

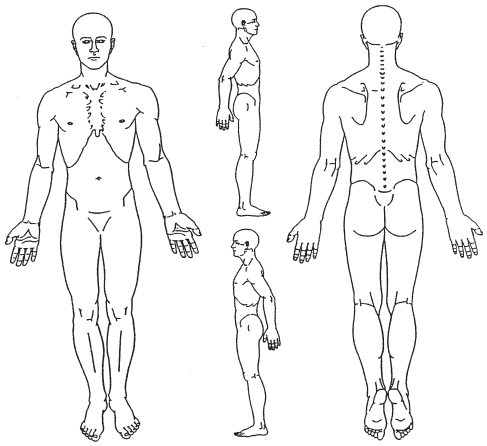
P=Pain

PN=Pins & Needles

ST=Stabbing

S=Stiffness

W=Weakness



Level of pain at REST: 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Level of pain while ACTIVE: 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Feels worse in the: Morning___ Afternoon___ Night ___

Feels worse with: Activity___ Sitting___ Standing___ Twisting___ Bending___ Walking___

Are you experiencing any of these symptoms?: Blurred Vision___ Dizziness___ Irritablity/Mood Swings___ Chronic Fatigue___

Localized Tingling___ Nausea___ Ringing In Ears___ Sleep Disturbance___ Cold Limbs___ Ecchymosis___

Fever___ Heartburn___ Joint Stiffness___ Muscle Spasm___ Muscle Weakness___ Pale Bluish Skin___

Panic___ Runny Nose___ Shortness of Breath___ Sweating___ Swelling___ Vomiting___

Does the pain radiate? Left___ Right___ Both Sides___ No Radiation___

Is there weakness present? Left___ Right___ Both Sides___ No Weakness___

Symptoms better with? Nothing___ OTC Meds___ RX Meds___ Cold___ Heat___ Massage___

Movement___ Sitting___ Standing___ Stretching___ Walking___

Do you suffer from any conditions other than what is listed above? _____

CURRENT MEDICATIONS

Medication_____Dosage_____ For Which Condition?_____ For How Long?_____

Medication_____Dosage_____ For Which Condition?_____ For How Long?_____

HEADACHES

Are you here for headaches? Yes___ No___

Location: Occipital___ Frontal___ Left Temporal___ Right Temporal___ Parietal___ Sinus___

Quality: Dull___ Sharp___ Throbbing___ Stabbing___ Aura___ No Aura___

Types: Hat Band___ Cluster___ Migraine___ Tension___

Other: How often?_____ How long?_____ What time of day?_____

Does the pain radiate? Yes___ No___ If Yes: Left___ Right___ Both___

Is body weakness present? Yes___ No___

FOOT PAIN

Are you here for foot pain? Yes___ No___

Location: _____

Quality: _____

HISTORY OF INJURIES Check ALL Injuries and Approximate Year

Back Injury _____ MVA _____ Broken Bones _____ Head Injury (loss of consciousness) _____

Head Injury (no loss of consciousness)_____ Soft Tissue Injury (mild)_____ Soft Tissue Injury (moderate)_____

Soft Tissue Injury (severe) _____ Fall(severe) _____ Joint Injury _____

Other_____

HISTORY OF SURGERIES List ALL Surgical Procedures and Approximate Year

_____

_____

_____