

Your History

Last Name _____ First Name _____ Home Phone _____
Work Phone _____ Cell Phone _____ Email _____
Address _____ City _____
Postal Code _____ Occupation _____
Marital Status M S D W Date of Birth Day _____ Month _____ Year _____ Age _____
of Children _____ If you take any over the counter drugs or medication please list:

Please list all Surgeries and date _____

Who referred you to our office? Family member Friend The Voice Newspaper
 Google Yellowpages (Big) Yellowpages.ca Canada411.com Walk- by
 Radio TV Other (Please describe _____)

Are you here for: Preventative Care/Wellness Health Problem

If you have a Health Problem please describe: _____

Your spinal cord controls every system in your body. Check areas where you have pain and any other health problems that apply:

Neck L R Shoulder L R Wrist L R Low Back L R Sciatica L R Knee L R Foot L R
When I have the pain it feels like : Burning Stabbing Stiffness Tingling Numbness

Poor Vision/Hearing Headaches Migraines Dizziness Poor Memory Anger
 Depression Anxiety Poor Sleep Low Energy Acid/Gas Digestive Issues
 Shortness of Breath Constipation/Diarrhea Weakness in the Body
Other: _____

History of Physical Stress (eg. sports injury, falls, car accidents)

History of Chemical Stress (eg. smoking, drinking, recreational drugs)

History of Emotional Stress (eg. loss of loved one, loss of job, divorce)

Rate your overall health level	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate your career satisfaction	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate your overall stress level	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate your overall happiness level	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate your commitment to improve your health	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate how often you take a vacation	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate how often you take time to relax	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate the likelihood that you'll skip a meal	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate your daily water intake	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate your level of exercise	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate your quality and quantity of sleep	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Rate the support you have from family and friends	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High

By signing below – I acknowledge all information is true and give Dr. Sandy Bhasin full permission to carry out any examination of my spine including use of thermal scan.

Patient's Signature _____ Date _____
Dr. Sandy Bhasin's Signature _____ Date _____

