

DR. ZIELONKA AND HIS TEAM WELCOME YOU TO OUR OFFICE.

Please complete all of the requested information. Your answers will help us determine if we can help you. If we do not sincerely believe that we can help you we will not accept your case. Thank you.

CONFIDENTIAL PATIENT INFORMATION

Name _____	Date _____
Address _____	
City, Province _____	Postal Code _____
Tel. (Home) _____	(Bus) _____ (Cell) _____
E-mail _____	
Date of Birth Day() Month() Year()	Age _____ Spouse's Name _____
Children _____	Your Occupation _____

How did you hear about our office?

Doctor _____ Other Health Professional _____

Friend _____ Spouse Other relative _____

Lecture series Internet Work in same building TV Book Yellow pages Sign

Newspaper Women's Show Other _____

WILL A CLAIM BE MADE AS THE RESULT OF A MOTOR VEHICLE ACCIDENT? Yes No

PRIOR CHIROPRACTIC CARE? Yes No Why? _____

When? _____ Name: _____ Telephone: _____

Results: Excellent Good Fair Poor X-rays taken: Yes No

PRIOR PHYSIOTHERAPY CARE? Yes No Why? _____

When? _____ Name: _____ Telephone: _____

Results: Excellent Good Fair Poor X-rays taken: Yes No

MEDICAL DOCTOR:

Name _____ Address _____ Phone _____

Would you like us to send a report to your medical doctor informing them of your condition and progress? Yes No

WHEN WAS THE DATE OF YOUR LAST SPINAL EXAM? _____

DO YOU WEAR CUSTOM MADE ORTHOTICS? Yes No

When were they fitted? _____ When were they last tested for function? _____

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in a serious loss of health where the effects are gradual and not even felt until they become serious. Our centre prides itself on helping people achieve and maintain a lifetime of optimum health; however, we also respect that only you can decide your health goals. We focus on your ability to be healthy. Our goals are first to address the issues that brought you to our centre and second to offer you the opportunity of improved health and wellness in the future. Please check your health goals and the type of care you wish to receive in our centre.

- LIFETIME OPTIMAL HEALTH (WELLNESS CARE)**
I wish to achieve optimal health and nervous system function for increased energy, vitality and longevity.
- CORRECTIVE CARE (RESTORATION)**
I am interested in a complete health program to not only relieve my symptoms but to also correct its underlying cause and to restore my maximum level of function.
- CRISIS CARE**
I am only interested in relieving the pain and / or symptoms of my problem.

PATIENT PAST HISTORY FORM

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 N = Never

C F O N

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 N

- 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 N

SKIN

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

GENITO-URINARY

- bed 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 menstruation date: _____

Pregnant: Yes No

Due date: _____

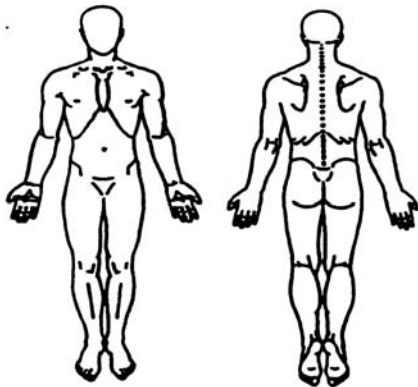
REASON FOR CONSULTING THIS OFFICE:

What's most important to you about the care that you receive in our office? _____

What needs to happen for you to feel that we've achieved this? _____

What do you hope to do better or enjoy more when you regain your health? _____

Please show any and all area(s) of pain or unusual feelings using the appropriate symbols below.



Numbness	●●●●●●●●
Pins & Needles	○ ○ ○ ○ ○
Burning	X X X X X
Aching	* * * * *
Stabbing	/ / / / / / / /

Please make a mark (/) through the line at the point of which you think represents your current level of pain in your major area of complaint.

NO PAIN _____ PAIN AS BAD
AT ALL _____ AS COULD BE

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS & CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various models of physical therapy and, if necessary, diagnostic x-rays, on me by Dr. Zielonka, his associate(s) or any locum chiropractor.

I have had an opportunity to discuss with the doctor(s) of chiropractic and/or with the office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's name (print)

Patient's signature
(or parent / guardian)

Witness

Date

PLEASE TELL US ABOUT ANY SPECIFIC PROBLEM WHICH BRINGS YOU TO OUR OFFICE

How long have you had it? _____

What do you attribute it to? _____

Have you had this before? _____ When? _____

If yes, what was the diagnosis and treatment? _____

Does the pain travel anywhere? _____

Is it becoming worse? _____ better? _____ constant? _____ varies? _____

Is the pain sharp dull aching numbness burning pins and needles

What makes it worse? _____ What makes it better? _____

Does it interfere with your work? sleep? daily routine?

List any stress: _____

Falls and Accidents – please list: _____

Surgery and Operations – please list: _____

Surgery recommended but not performed, list: _____

Have you ever been in a motor vehicle accident? Yes No When? _____

Have you ever been knocked unconscious? Yes No If so, for how long? _____

List any medication or drugs you are currently taking: _____

Have you been previously hospitalized? Yes No Please list _____

Any family health conditions or problems? Yes No Please list _____

Have you ever had any of the following? heart conditions strokes hepatitis polio

aneurysm osteoporosis diabetes arthritis epilepsy cancer HIV

HEALTH HABITS

Do you smoke? Yes No Rate your sleep: Poor Fair Good Do you wake rested? Yes No

Do you exercise? Yes No Please list _____

Rate your nutrition: Poor Fair Good Excellent Do you consume vitamins Yes No

Please list: _____

Do you belong to a health club? Yes No Do you buy bottled water? Yes No

Is there anything else Dr. Zielonka or his health team should know?

Dr. John Zielonka B.Sc., D.C., C.O.H., A.R.T., C.C.R.D. & Associates

OTTAWA CHIROPRACTIC & NATURAL HEALTH CENTRE

World Exchange Plaza, Ground Floor

111 Albert Street, Ottawa K2P 1A5

(613) 688-1036

www.excellenceinhealth.com

Your appointment is on _____ at _____. Please call us 24 hours in advance if you must re-schedule. We look forward to being of service to you.

Ottawa's Premier Centre for Health and Wellness