Guardian Family Chiropractic
127 Church Street
St. Catharines, ON L2R3E2
Ph: 289-273-581

Introduction

Welcome to Guardian Family Chiropractic

Your first visit or reservation at Guardian Family Chiropractic will give us an opportunity to learn about each other. Please take your time to complete to the best of your knowledge the initial intake forms and then submit online. Before you submit please read through consent for examination and chiropractic care, sign at the end electronically using the mouse if using a computer or finger if using an iPad or tablet on the touch screen. We will receive your intake forms electronically, so there is no need to print your documents.

During your first appointment with us, we will go over your current health and review your vital information to give us the information we need. At the same time, you will have the opportunity to interview us about our chiropractic philosophy and technique and tell us about your concerns and wishes.

After completing the initial paperwork, Dr. Cheema will then do a complete analysis of your nervous system. Typically at the end of your first appointment, you will receive your first adjustment if further diagnostic procedures are not needed. If you are new to chiropractic, you will likely have many questions for us. We like to answer your questions about chiropractic, so you are comfortable and at ease. If you are moving to St. Catharines or the Niagara Region and are looking for a new chiropractor, you will likely have questions, as well.

Your first appointment will be all about helping you feel comfortable that you are making an informed decision about your chiropractic care. And, it does not stop with your first appointment, as we are always here to talk to you about your care or care for your family members. We are always happy to answer questions, discuss issues, and find the best path to wellness for you.

Contact

First Name_____ Last Name_____

Address _____

City_____ Prov_____ Postal_____

Home Phone _____ Cell Phone _____

Other Phone _____ Email _____

Gender Male Female Birthdate _____

Height _____ Shoe Size _____ Weight _____

Marital Status Single Married Divorced Widowed

Spouse _____ Num. of Children _____ Names/Ages _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about us? None Patient Physician Attorney Advertisement

_____

Family Physician _____ Date of Last Visit _____

Physician Phone _____

Work Status Full Time Part Time Disability Student Retired Unemployed

Employer _____ Occupation _____ Employer Phone _____

Employer Address _____

Have you missed work due to this injury? Yes No

Missed work start date? _____ Return or anticipated return date _____

Condition

The Symptoms that have prompted you to seek care today include: _____

Have you seen other doctors for this condition? Yes No

_____

Prior Interventions Acupuncture Chiropractic Heat Homeopathic Ice Massage Medication OTC Meds Physiotherapy Surgery Other

_____

What is the condition related to? Auto Accident Home Injury Sports Injury Work Injury Other

_____

When did your problem first start? _____

Have you had this condition before? Yes No

_____

Does the pain radiate or travel to other parts of the body? Yes No

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Does anyone from your family suffer from the same condition? Yes No

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What makes the condition worse? Bending Coughing Defecation Lifting Sitting Sneezing Stairs Standing Walking Other

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What makes the condition better? Bed Rest Heat Ice Massage Medication Other

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Does this condition affect employment? Yes No

Does this condition affect recreation? Yes No

Does this condition affect household? Yes No

Does this condition affect personal? Yes No

Does this condition affect sleep? Yes No

What else should we know about your current condition? _____

Rate the severity of your pain from 0 to 10

No Pain Excruciating Pain

Pain Duration Constant Intermittent

Current Medications Blood Pressure Insulin Muscle Relaxants Nerve Pills Pain Other

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Supplements Yes No

Sleep Position Back Left Side Right Side Stomach

Hours of sleep per night? (1-24)_____

Have you had x-rays in the last six months? Yes No

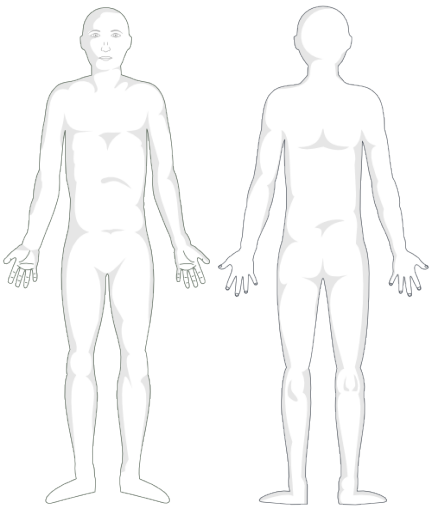
I realize that x-ray examinations may be hazardous to an unborn child. I certify to the best of my knowledge I am not pregnant.

Yes No

Last Cycle: _____

Pain

Please Select the Area(s) that you are experiencing pain?



Systems

Select options below indicating age at diagnosis and other relevant details.

Musculoskeletal Osteoporosis

Back Problems

Knee Injuries

Arthritis

Hip Disorders

Foot/Ankle Pain

Scoliosis

TMJ Issues

Shoulder Problems

Elbow/Wrist Pain

Neck Pain

Poor Posture

Neurological Anxiety

Headaches

Dizziness

Depression

Numbness

Pins and Needles

Cardiovascular High Blood Pressure

Poor Circulation

High Cholesterol

Low Blood Pressure

Chest Pain

Respiratory Asthma

Shortness of Breath

Emphysema

Apnea

Pneumonia

Allergies

Digestive Anorexia or Bulimia

Constipation

	Food Sensitivities
	Ulcer
	Diarrhea
	Heartburn
Sensory	Blurred Vision
	Nose Bleeds
	Chronic Ear Infections
	Ringing in Ears
	Sore Throat
	Loss of Smell
	Hearing Loss
Integumentary	Skin Cancer
	Rash
	Acne

	Psoriasis
	Bruise Easily
	Hair Loss
	Eczema
	Slow Healing
Endocrine	Thyroid Issues
	Swollen Glands
	Low Blood Sugar
	Immune Disorder
	Low Energy
	Frequent Infection
Genitourinary	Kidney Stones
	Prostate Issues
	Bedwetting
	Infertility

PMS Symptoms

General Fainting

Loss of Appetite

Sudden Weight Gain

Fatigue

Loss of Sleep

Weakness

Sudden Weight Loss

History

Personal Illness History Aids Alcoholism Allergies Arteriosclerosis Cancer Chicken Pox Diabetes Epilepsy Glaucoma Goiter Gout Heart Disease Hepatitis HIV Positive Malaria Measles Multiple Sclerosis Mumps Polio Rheumatic Fever Scarlet Fever STD Stroke Tuberculosis Typhoid Ulcer Other

Surgery/Trauma History Cancer Back Surgery Bypass Surgery Hernia Other

Fractures Yes No

Auto Accident Yes No

Spinal Injury Yes No

Hospitalization Yes No

Alcohol Use None Daily Weekly

Coffee Use None Daily Weekly

Tobacco Use None Daily Weekly

Exercise None Daily Weekly

Pain Reliever None Daily Weekly

Soft Drinks None Daily Weekly

Water Intake None Daily Weekly

Family History

Mother Age

Age At Death

Illness

Health Good Bad

Father Age

Age At Death

Illness

Health Good Bad

Sibling Age

Age At Death

Illness

Health Good Bad

Sibling Age

Age At Death

Illness

Health Good Bad

Finalize

What is the most significant thing you can do to improve your health? _____

How committed are you at achieving your maximum health potential

How do you want us to handle your problem? Temporary Relief Maximum Correction

Please Read the following carefully before signing.

Consent for Chiropractic Examination

In order to establish a care plan, Dr. Hafiz Cheema must perform an examination and may request other clinical services to determine the exact issues of your complaint(s). I hereby authorize Dr. Hafiz Cheema and whomever he designates to administer a physical examination, or any other clinical service deemed necessary to reach a clinical decision/diagnosis needed to develop an appropriate care plan. I also understand that some procedures or maneuvers may be performed that are intended to reproduce my symptoms and could cause a temporary exacerbation of my symptoms.

Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understands the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives. Chiropractic is a science, philosophy, and art, which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors, we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity. Disturbance or irritation to the nervous system may be caused by vertebral subluxation. A subluxation refers to structural misalignment or fixation between two or more adjacent vertebrae or other joints, causing nerve irritation and resultant alteration in normal mechanical and neurological functions of the body. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific chiropractic procedure used to eliminate or reduce a subluxation, thereby restoring normal neural transmission to the involved area, and assisting the body?s natural ability to achieve maximum health. Adjustments are done by hand where the doctor will put optimal pressure on the specific segments of the joints. Delay of treatment allows the formation of fibrosis, adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay in treatment will complicate the condition and make future rehabilitation more difficult. If at the beginning or during care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider. All questions regarding the doctor's objective to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care

have been explained to me to my satisfaction. In the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts known to him or her, to be in my best interest. I have read and fully understand the above statements and therefore accept chiropractic care on this basis. I acknowledge that all the information provided in these forms, including patient demographics, past and present medical history, social and family history is accurate.

*If under the age of 18, please complete on behalf of your child.

**Please sign below before completing.

**After agreeing, please Sign and Submit

Signature