Dr. Stephanie Estima Galanis DC Dip AC, C.A.C.C.P. [cand.]
Dr. Lara Smythe, DC , Med. Ac
47 Stewart Street | Toronto ON M5V 2V8
o: 647 346 2281 f: 647 436 5547
w: thehealthloft.ca

Confidential Patient Information (please use BLOCK LETTERS)

Personal Details

Prefix: Dr Mr Mrs Ms Miss ______________________

Last Name First Name Inital(s)

____

Address City Province Postal Code

( ) - ( ) - ( ) - / /

Home Phone No. Work Phone No. Mobile Phone No. Date of Birth (mm/dd/yy)

____

Gender (M/F) Occupation e-mail address

Who referred you? ______________________

Health Information

( ) -

Name of Medical Doctor Telephone No. Address

____

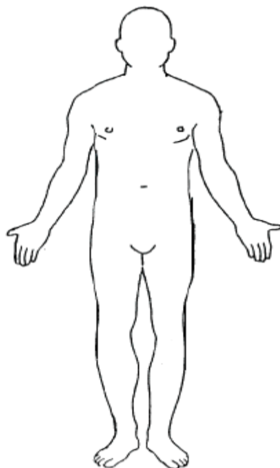
Date of Last Appointment Date of Last Physical

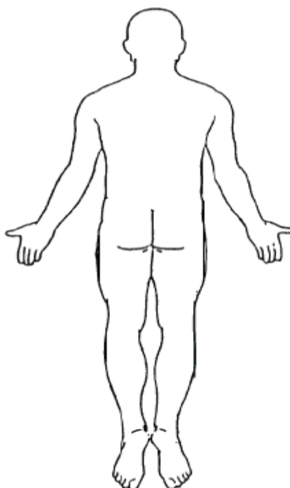
Emergency Contact

( ) - ( ) -

Name Relationship Daytime Phone Evening Phone

Pain Diagram





Please shade and code areas to indicate location of pain or discomfort.

P – Pins & Needles

N – Numbness

S – Spasm

T – Tenderness

A – Aches

R – Radiations

B – Burning

X - Stabbing

Dr. Stephanie Estima Galanis DC Dip AC, C.A.C.C.P. [cand.]
Dr. Lara Smythe, DC , Med. Ac
47 Stewart Street | Toronto ON M5V 2V8
o: 647 346 2281 f: 647 436 5547
w: thehealthloft.ca

the health loft
by dr | stephanie

Symptoms

1. What is your principal problem or the one area of greatest pain?

   ____

2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is extremely severe pain.

   0 ____ 10

3. Do you think the pain has been getting worse? Yes / No
   If so, how quickly has it increased? Gradually / Suddenly

4. What do you think caused this problem?

   ____

5. How often do you experience this pain?

   ☐ 1-2 hrs per day ☐ About half the day ☐ Most of the day ☐ The pain is constant

6. How does the pain affect your daily activities?

   ☐ It does not affect them ☐ I have had to change how I do things
   ☐ I have had to stop doing some of them ☐ I am unable to perform most daily activities

7. What increases your pain? ____

8. What decreases your pain? ____

9. Have you experienced this problem in the past? Yes / No If so, when? ________________

10. Which of the following treatments, if any, have you received for your complaint?

    ☐ Medication ☐ Physical Therapy ☐ Massage
    ☐ Chiropractic ☐ Acupuncture ☐ Other

11. Which of the above treatments have benefitted you the most?

    ☐ Medication ☐ Physical Therapy ☐ Massage
    ☐ Chiropractic ☐ Acupuncture ☐ Other

12. What do you expect from your visit to the clinic? ____________________________

13. Do you have a pacemaker or any metal implants (e.g. screws)?

    If so, explain: ____

14. List any other issues currently bothering you and rate the pain level for each.

    a. __________________________ 0 ______________________ 10
    b. __________________________ 0 ______________________ 10

15. Have you ever been involved in an auto accident? Yes / No
    If Yes, when? ______________________
    Were you injured? Yes / No If yes, complete the **Motor Vehicle Accident Form**

16. Have you ever been injured at work? Yes / No
    If Yes, when? ______________________ If yes, please complete the **Workplace Injury Form**

Dr. Stephanie Estima Galanis DC Dip AC, C.A.C.C.P. [cand.]
Dr. Lara Smythe, DC , Med. Ac
47 Stewart Street | Toronto ON M5V 2V8
o: 647 346 2281 f: 647 436 5547
w: thehealthloft.ca

Medical History / Other

1. Please list all medications you are currently taking (including vitamins and over the counter medication).

2. Please list all surgeries you have had with date(s). ______________________________

3. Diet: Please rate your diet on the following scale: 0 = poor, 5 = healthy 0 ____________ 5
   Meals: ___ per day Tobacco: ___ cigarettes per day Alcohol: ___ drinks per week
   Allergies / Other Dietary Concerns:
   ____

4. Exercise: Cardiovascular: ___ x / week Weights: ___ x / week

5. If female, when was your last period? ______________________________

6. If female, are you pregnant? Yes / No / Unsure

7. Below are several lists of diseases and conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care. Please check all that apply.

Diseases

☐ AIDS	☐ Anaemia	☐ Cancer	☐ Chicken Pox	☐ Diabetes
☐ Eczema	☐ Heart Disease	☐ Hepatitis A B C D	☐ Influenza	☐ Mental Disorder(s)
☐ Pneumonia	☐ Psoriasis	☐ Rheumatic Fever	☐ Smallpox	☐ Stroke / ITA
☐ Thyroid	☐ Arthritis	☐ Tuberculosis	☐ Other	____________

Cardiovascular & Pulmonary System

☐ Chest pain	☐ Heart problems	☐ Varicose veins	☐ Ankle/calf swelling	☐ Irregular heartbeat
☐ Stroke	☐ Blood pressure	☐ Lung problems	☐ Congestion	☐ Shortness of breath

Gastrointestinal System

☐ Abnormal appetite	☐ Gas / bloating	☐ Upset stomach	☐ Frequent nausea	☐ Colitis
☐ Heartburn	☐ Diarrhea	☐ Excessive thirst	☐ Ulcers	☐ Hemorrhoids
☐ Vomiting	☐ Weight trouble	☐ Gall bladder	☐ Constipation	☐ Dark / bloody stool
☐ Abdominal cramps	☐ Liver problems	☐ Irritable bowel		

Genitourinary & Musculoskeletal Systems

☐ Bladder trouble	☐ Vaginal pain	☐ Breast pain/lumps	☐ Sexual dysfunction	☐ Difficulty chewing
☐ Joint pain/stiffness	☐ Menstrual cramps	☐ Vaginal infection	☐ Menstrual irreg'y	☐ Low back pain
☐ Clicking jaw	☐ Neck pain	☐ Discoloured urine	☐ Painful urination	☐ Prostate problems
☐ Walking difficulties	☐ Pain b/w shoulders	☐ Wrist / hand pain	☐ Arm pain	☐ General stiffness

Nervous System / EENT

☐ Nervousness	☐ Numbness	☐ Fainting	☐ Paralysis	☐ Depression
☐ Confusion	☐ Forgetfulness	☐ Dizziness	☐ Tingling	☐ Vision problems
☐ Ears ringing	☐ Ears buzzing	☐ Stress	☐ Dental problems	☐ Sore throat
☐ Vertigo	☐ Hearing difficulties	☐ Grinding teeth		

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: ______________________________ Date: ______________________________

Dr. Stephanie Estima Galanis DC Dip AC, C.A.C.C.P. [cand.]
Dr. Lara Smythe, DC , Med. Ac
47 Stewart Street | Toronto ON M5V 2V8
o: 647 346 2281 f: 647 436 5547
w: thehealthloft.ca

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of Chiropractic, Medical Doctors and Physiotherapists who use manual therapy techniques such as spinal adjustments and manipulations are required to advise patients that there are some risks associated with such treatment. In particular, you should note:

a. While rare, some patients have experienced muscle strain, ligamentous sprain and rib fracture following spinal adjustments or manipulation.

b. There have been reported cases of injury to the vertebral artery (blood vessel located in the neck) following adjustment or manipulation to the neck (cervical spine). Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment. The possibility of such injuries resulting from neck and spinal adjustment or manipulation is extremely rare.

c. There have been rare reported cases of disc injuries following neck or low back spinal adjustment or manipulation. However, scientific study has not supported that such injuries are caused, or may be cause, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment or manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years. These reports and studies have demonstrated that chiropractic treatment to be effective for spinal pains, headaches, and other similar symptoms.

Chiropractic care may contribute to your overall well being. The risk of injuries or complication from chiropractic treatment is substantially lower than that associated with other treatments, medications, and procedures given for the same symptoms.

I, _________________________, acknowledge that I have discussed or have had the opportunity to discuss, with my chiropractor, the nature and purpose of my treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the treatments offered or recommended to me by my chiropractor including spinal adjustment. I intend this Consent to apply to my present and future chiropractic care.

Dated this __________ day of __________, 20___.

Patient Signature: ____________________ ____________________

____________________ ____________________

Dr. Stephanie Estima Galanis DC Dip AC, C.A.C.C.P. [cand.]
Dr. Lara Smythe, DC , Med. Ac
47 Stewart Street | Toronto ON M5V 2V8
o: 647 346 2281 f: 647 436 5547
w: thehealthloft.ca

Financial Policy

Payment

- Payment for all services is due when rendered.

Cancellation Policy

- We would appreciate at least 24 hours notice if you are unable to keep your scheduled appointment. If we do not receive this notice then you may be responsible for the fee of the scheduled visit.

Non-Payment Procedures

- Should you have an appointment and leave the premises without making payment, we are entitled to charge the appointment fee to your credit card.

Credit Card Type ____

Credit Card Number ____

Name as it appears on Card ____

Expiry Date ____

I, ___________________________________, have read the above and understand that I am personally responsible for paying the fees for all services rendered. I authorize The Health Loft to charge any fees due as per the Financial Policy to the credit card information provided above.

Name ___________________________________

Signature ___________________________________

Date ___________________________________