



DR. GRAHAM KUCAN, BSc., DC.

Chiropractor
CCO #5008

KUCAN CHIROPRACTIC & ACUPUNCTURE CLINIC

285-12th Street, Hanover, ON · 519-364-3020 · info@kucanclinic.com

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile and diagnosis for you. All of your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets. **PLEASE RETURN THESE FORMS NO LATER THAN 24 HOURS BEFORE YOUR INTIAL APPOINTMENT, IF POSSIBLE.** Thank you.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Occupation: _____

Is it OK to leave a message at home? YES/NO On your cell? YES/NO At work? YES/NO

Referred by: _____ Physician: _____

Emergency Contact: _____ Phone: _____

Have you had any imaging done? Please include as much information as possible (ie. Dates, location)

Have you ever seen a Chiropractor before? YES/NO

If yes, please tell me what the experience was like.

MAIN COMPLAINT (Symptoms? Diagnosis? When and how did it start?)

What makes your condition BETTER? (Rest, movement, heat, cold, medication, etc.)

What makes your condition WORSE? (Stress, position, activity, heat, cold, foods, weather, time of day/month, etc.)

What other interventions have you tried? (Doctors, tests, therapies, medications, supplements, etc?)

YOUR MEDICAL HISTORY:

Accidents or Traumas (Falls, accidents, car accidents, work injuries, sports injuries, etc.)

Surgeries (Please include dates)

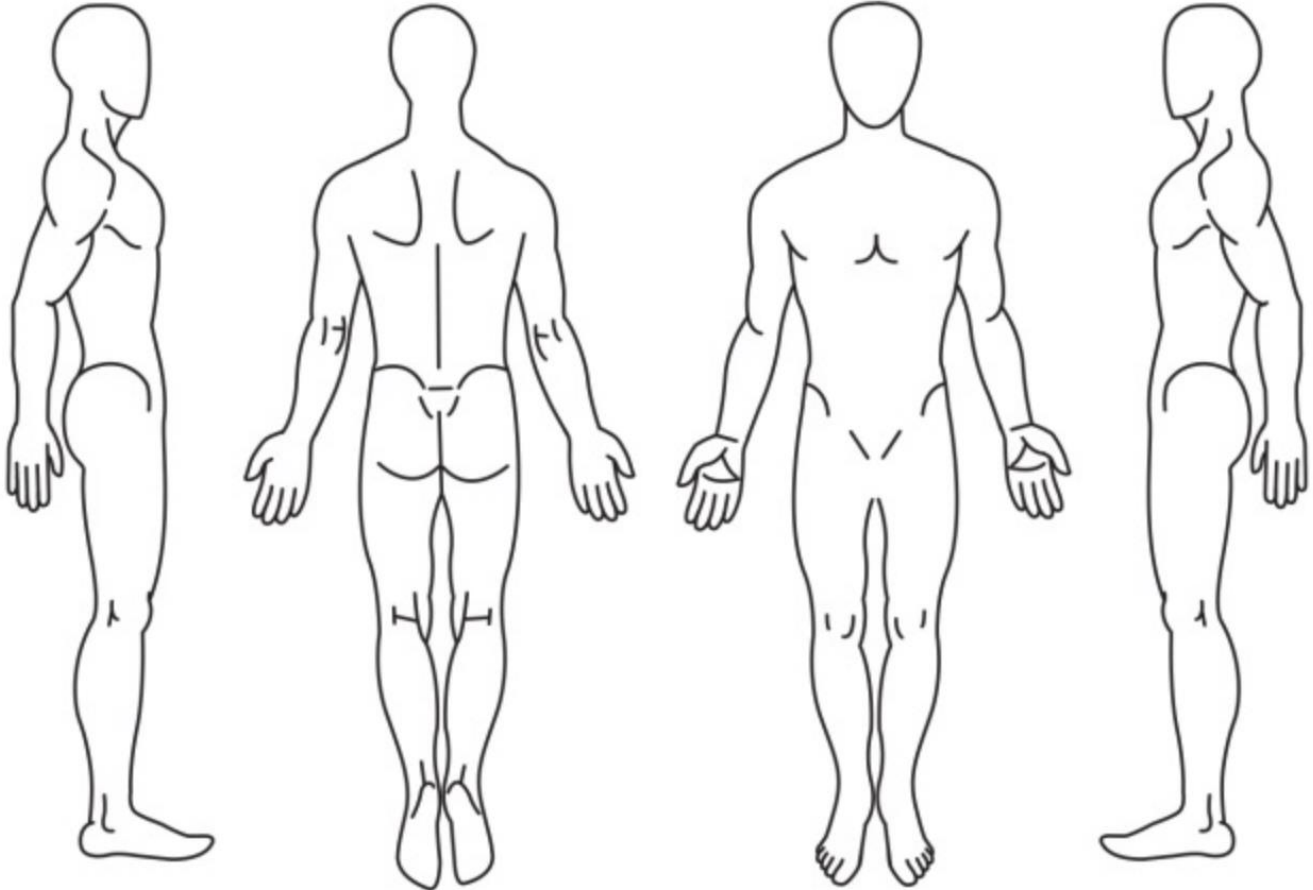
Surgeries recommended but not performed

Medications (including names & dosages; please attach an additional page if necessary)

Vitamins/Supplements/Herbs (please attach an additional page if necessary)

Using the appropriate symbols, please indicate all areas of pain, unusual feelings or discomfort.

<u>Ache</u> AAAA	<u>Burning</u> BBBB	<u>Numbness</u> NNNN	<u>Pins/Needles</u> PPPP	<u>Stabbing</u> SSSS	<u>Other</u> OOOO
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PERSONAL HEALTH HISTORY (Please check any condition or symptoms that YOU HAVE NOW, OR HAVE EVER HAD IN THE PAST)

- | | | |
|--|--|---|
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Food allergies/intolerances | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Fracture | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gastritis/pancreatitis | <input type="checkbox"/> Lyme disease |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Birth trauma (your own birth) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hyperglycemia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Crohn's/Colitis | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Liver/gallbladder disease | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low blood pressure | _____ |

EXERCISE

Days per week? _____ Types of activities? _____ Length of workout? _____

LIFESTYLE

Meals per day? _____ Snacks? _____ Caffeine? _____ Water? _____

Alcohol per week? _____ Smoking/Vaping? _____ Recreational drugs? _____

FAMILY MEDICAL HISTORY (Please check any condition THAT APPLIES TO YOUR IMMEDIATE FAMILY. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), or GF (grandfather) in the blank.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Addiction _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Thyroid disorder _____ | _____ |

Please CHECK if you have had any of the following symptoms IN THE LAST YEAR.
Please CIRCLE if you have had any of the following symptoms IN THE PAST, BUT DON'T ANY LONGER.

GENERAL

- Poor appetite
- Insomnia/poor sleep
- Shift work
- Fatigue
- Dizziness
- Sudden energy drop
- Weakness
- Heaviness
- Chills/Cold
- Feverishness/Heat
- Night sweats
- Nausea
- Sweats for no apparent reason
- Tremors/tics
- Poor balance/frequent falls
- Bleed/bruise easily
- Weight loss
- Weight gain

SKIN AND HAIR

- Rash
 - Itching
 - Dryness
 - Eczema/psoriasis
 - Hair Loss
 - Recent moles
 - Ulcerations
 - Hives/Allergic Dermatitis
 - Warts
 - Weak/ridged nails
-
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HEAD, EYES, EARS, NOSE AND THROAT

- Eye strain/pain
 - Eye redness/itching/dryness
 - Poor/blurry vision
 - Glasses
 - Night blindness
 - Color blindness
 - Floaters
 - Cataracts
 - Glaucoma
 - Headaches
 - Migraines
 - Dizziness
 - Vertigo
 - Ringing in ears
 - Earaches
 - Poor hearing
 - Facial pain/pressure
 - Sinus problems
 - Environmental allergies
 - Post-nasal drip
 - Nose bleeds
 - Jaw pain/clicks/locks
 - Grinding/clenching teeth
 - Dental/gum problems
 - Dry mouth
 - Peculiar tastes/smells
 - Sores on lips/tongue
 - Recurrent sore throat/colds
 - Difficulty swallowing
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RESPIRATORY

- Cough/wheezing
 - Asthma
 - Bronchitis
 - Pneumonia
 - COPD
 - Emphysema
 - Pain with deep inhalation
 - Tight sensation in chest
 - Coughing up blood
 - Difficulty inhaling/ exhaling
 - Difficulty breathing when laying down
 - Difficulty breathing with exertion
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CARDIOVASCULAR

- Chest pain
 - Chest pressure
 - Irregular heartbeat
 - Palpitations at rest
 - Fainting
 - Cold hands/feet
 - Swelling of hands/feet
 - Shortness of breath
 - Blood clots
 - Varicose/Spider veins
 - Phlebitis
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GASTROINTESTINAL

- Burping or gas
- Vomiting
- Abdominal pain/cramping
- Constipation
- GERD/acid reflux
- Food intolerances _____
- Diarrhea
- Hiatal hernia
- _____
- Stomach pain
- Bloating/edema

GENITO-URINARY

- Frequent urination
- Pain on urination
- Difficulty forming stream
- Urgent urination
- Burning on urination
- Dribbling after urination
- Unable to hold urine
- Cloudy urine
- Urinary tract infection
- Night urination... What time? _____ How often? _____

FOR WOMEN ONLY

- Back pain with cycle
- Last menstruation date? _____
- Pregnant? _____
- Menopausal

MUSCULOSKELETAL

- Arm/elbow pain
- Leg pain
- Numbness in legs/feet
- Bursitis
- Lower back pain
- Osteoporosis/Osteopenia
- Carpal tunnel syndrome
- Mid back pain
- Rotator cuff/shoulder pain
- Degenerative Disc Disease
- Muscle pain
- Sciatica
- Dislocated joints
- Muscle weakness/fatigue
- Scoliosis
- Foot/ankle pain
- Muscle spasms
- Sprains/strains
- Hand/wrist pain
- Muscle stiffness
- Tendonitis/Tendinosis
- Hip pain
- Neck pain
- Knee pain
- Numbness in arms/hands

NEUROPSYCHOLOGICAL

- Nerve pain
- Concussion
- Easily susceptible to stress
- Numbness
- Depression
- Seasonal Affective Disorder
- Seizures
- Nervousness
- ADD/ADHD
- Poor balance/falling
- Anxiety/panic attacks
- Bipolar disorder
- Lack of coordination
- Restless/jittery
- OCD
- Poor memory
- Difficulty sleeping
- PTSD
- Difficulty concentrating
- Bad temper/irritable
- Other _____

COMMENTS

Please inform me of any other issues you would like to discuss.



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Privacy Code

The privacy of your personal information is important to the Kucan Chiropractic and Acupuncture Clinic. We are committed to the collection, storage, use and disclosure of this information in a responsible way.

Personal Information:

Personal information is information about an identifiable individual. Generally, the information we collect is limited to name, home contact information, gender and age. As part of your patient file, we retain your health history, health measurements and examination results, health conditions, assessment results and diagnosis, the health services provided to you or received by you, your prognosis and other opinions formed, compliance with treatment and the reasons for your discharge and discharge recommendations. We may also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent. The use, retention and destruction of your personal information complies with existing legislation and privacy protection protocols. These standards are set by our regulatory body, the College of Chiropractors of Ontario (CCO) and the law.

Clinicians and Staff Members:

Clinicians and staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to use. They are trained in the appropriate use and protection of your information. These individuals include clinic reception staff and other regulated health professionals, who work in the building.

Disclosure of Personal Information:

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinic will use and disclose information.

- to deliver safe and effective patient care
- to be able to contact you
- to communicate with your other health care providers, if and when you give us expressed permission to do so
- to complete and submit claims on your behalf to third party payers
- to comply with legal regulatory requirements under the Regulated Health Professions act and the Chiropractic Act.
- to process payments and collect unpaid accounts

Patient please initial here:

By signing the consent section of this form you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Contact Processes:

On occasion we may need to contact you regarding scheduling, cancellation or other issues related to your care. Please check the appropriate boxes below for the following forms of acceptable communications and fill in the appropriate number or email address for each selected option.

- Home phone _____
- Cell phone _____
- Work phone _____
- Mailing Address _____
- Email Address _____

RESTRICTIONS (please explain): _____

I have reviewed the above information that explains how the clinic uses my personal information, I know that I may ask to see this Privacy Code at any time.

I agree that Dr. Graham Kucan and the Kucan Chiropractic and Acupuncture Clinic can collect, use and disclose my personal information as set out above.

Patient Name

Witness Name

Patient Signature

Witness Signature

Date