Dr. Graham Kucan, BSc., DC.

Chiropractor
CCO #5008

Kucan Chiropractic & Acupuncture Clinic

285-12th Street, Hanover, ON · 519-364-3020 · KucanClinic@Wightman.ca

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. Thank you.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex/ Current Gender: _____ Relationship 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)

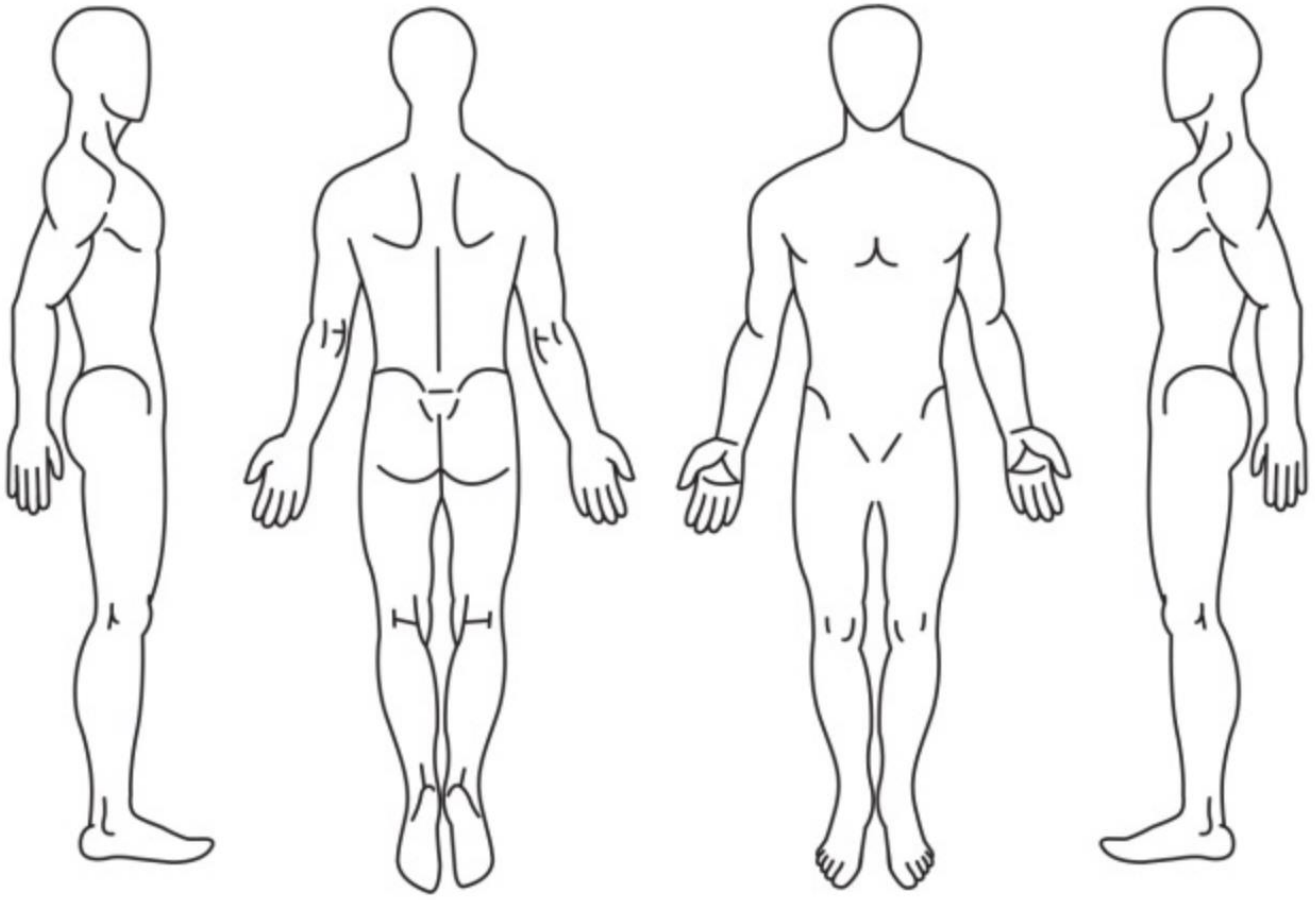
Surgeries recommended but not performed

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.

Ache	Burning	Numbness	Pins/Needles	Stabbing	Other
AAAA	BBBB	NNNN	PPPP	SSSS	OOOO



PERSONAL HEALTH HISTORY (Please check any condition or symptoms that YOU HAVE NOW, OR HAVE EVER HAD IN THE PAST)

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

EXERCISE

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

LIFESTYLE

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

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

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

- o Addiction _____
- o Allergies _____
- o Asthma _____
- o Cancer _____
- o Diabetes _____
- o Heart disease _____
- o High blood pressure _____
- o Thyroid disorder _____
- o Seizures _____
- o Stroke _____
- o Other _____
  _____

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

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

SKIN AND HAIR

- o Rash
- o Itching
- o Dryness
- o Eczema/psoriasis
- o Hair Loss
- o Recent moles
- o Ulcerations
- o Hives/Allergic Dermatitis
- o Warts
- o Weak/ridged nails

_____

_____

HEAD, EYES, EARS, NOSE AND THROAT

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

_____

_____

RESPIRATORY

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

_____

_____

CARDIOVASCULAR

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

_____

_____

GASTROINTESTINAL

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

GENITO-URINARY

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

MUSCULOSKELETAL

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

_____

_____

_____

NEUROPSYCHOLOGICAL

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

_____

_____

_____

COMMENTS

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

_____

_____

_____

_____

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KUCAN CHIROPRACTIC & ACUPUNCTURE CLINIC

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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