Oswell Chiropractic Centre
420 Talbot St. W., Aylmer, Ontario N5H 1K9 519-765-2565

Confidential Patient History - Laser

Name: _____ Date: _____
Address: _____ City: _____ Province: _____
Postal Code: _____Home Phone #: _____ Work Phone # / Other #: _____
Employer: _____Dr.'s Name _____
Date of Birth: _____ Sex: M / F MVA?_____ WSIB?_____
How did you hear about us? _____

Current Health Habits	Yes	No	Patients Comments	Doctor's Comments
Did/do you smoke?				
Did/do you drink any alcohol?				
Are you concerned about your diet?				
Have you been in accidents?				
Current medications? How Long?				
Allergies?				
Exercise regularly?				
Sleeping posture: side stomach back				
Females: Are you pregnant?				
Stress: physical, emotional, chemical?				
Did/do you have cancer? Type?				

Is there a family history of: Heart Disease____Arthritis____Cancer____Diabetes____Other_____
Present Complaint: _____
_____
Pain or problem started on _____
Pains are: Sharp____Dull____Constant____Intermittent____Travels____Comes& goes_____
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is condition worse during certain times of the day?_____
Is this condition interfering with your: Work? ____Sleep? ___Daily Routine? ____Walking?_Sitting?
Hobbies?____Other?_____
Is condition getting progressively worse? _____
Have you seen any other Doctors for this condition?_____
Any effective treatments? _____
Have you experienced any side effects from the drugs and surgeries? _____

Other Symptoms:

o	Headaches	o	Pins and Needles in legs	o	Fainting
o	Neck Pain	o	Pins and Needles in Arms	o	Loss of Smell
o	Sleeping Problems	o	Numbness in Fingers	o	Loss of Taste
o	Back Pain	o	Numbness in Toes	o	Diarrhea
o	Nervousness	o	Shortness of Breath	o	Feet Cold
o	Tension	o	Fatigue	o	Hands Cold
o	Irritability	o	Depression	o	Stomach Upset
o	Chest Pains	o	Light Bothers the Eyes	o	Constipation
o	Dizziness	o	Loss of Memory	o	Cold Sweats
o	Face Flushed	o	Ears Ring	o	Loss of Balance
o	Neck Stiff	o	Fever	o	Buzzing in Ears

PATIENT PAIN ASSESSMENT

0-10 Numeric Pain Intensity Scale

Example: No pain, Mild pain, moderate pain, severe pain, very severe, intolerable pain

1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

No pain 1 2 3 4 5 6 7 8 9 10 intolerable pain

2) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

No pain 1 2 3 4 5 6 7 8 9 10 intolerable pain

3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

No pain 1 2 3 4 5 6 7 8 9 10 intolerable pain

4) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

No pain 1 2 3 4 5 6 7 8 9 10 intolerable pain

5) What treatments or medications are you or have you received for your pain?_____

6) **Circle the one number that describes how, during the past 24 hours, pain has interfered with your:**

A. General activity: Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes

B. Walking ability: Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes

C. Normal work: [includes both work outside and inside the home]

Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes

D. Sleep: Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes

E. Enjoyment of life: Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes

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PATIENT CONSULTATION –Laser

Name:_____Date:_____

Main Complaint:_____
_____

History of Problem:_____ _____
_____
_____

Duration of Symptoms:_____
_____

Prior Therapy for current Conditions:_____
_____
_____

Physical Examination:_____
_____
_____
_____
_____
_____
_____
_____

Diagnosis:_____
_____

Report of Findings_____
_____

Tests Required:_____
Treatment Plan:_____
_____
_____