**Catania Chiropractic**

Dr. Paul Catania

320 Dundas St.

London, ON N6B 3R8

Name:

Address : City: Postal Code:

Home Phone: Business Phone: Cellular:

Email:

By providing your e-mail you consent to e-mail reminders for appointments and notices regarding special notices that affect my care from Catania Chiropractic.

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DD MM Y Y

Date of Birth: Gender: Male Female Marital Status: Single Married Divorced Widow

Number of Children: Occupation: Employer :

Have you ever had previous chiropractic care? Yes No With who?

Who referred you to our office?

State your primary complaint and/or concern:

When did it first start? Have you had it in the past? Yes, if so when No

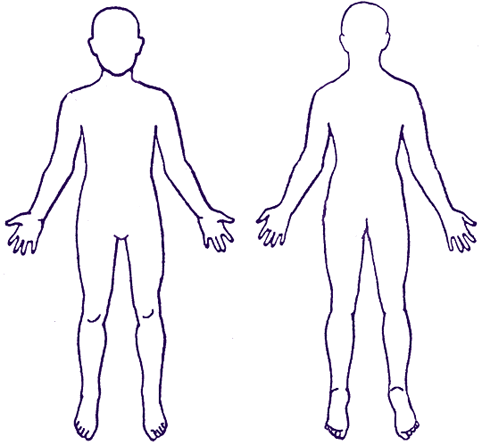
What makes it worse?

What makes it better?

Describe how it feels?

sharp dull achy throbbing numb tingling burning

stiff other(please explain)

Please circle the location of your complaint:

My condition is localized to a specific area

Or

It radiates to other parts of body, explain:

Is this condition: constant comes and goes getting worse with time

Systems Analysis

**Eyes, Ears, Nose & Throat**

Earache/Infections

Deafness

Ringing in ears

Sinus trouble

Allergies

Vision problems

**Muscle and Joint**

Backache

Neck pain

Hernia

Spinal curvature

Poor posture

Painful Tailbone

**Gastro-Intestinal**

Difficult digestion

Belching or gas

Nausea

Vomiting

Constipation

Diarrhea

Liver Trouble

Gall bladder trouble

Food sensitivity/allergy

**General**

Allergy

Loss of balance

Fainting

Diabetes

Skin problems

Hyperactivity

Please indicate any medications you are presently taking:

Please list any significant illness, operations, accidents, falls or traumas:

Date signed

Signature

Other:

**Personal Stress Levels**

Past Present

High

Moderate

Light

None

**Cardiovascular**

Rapid heart beat

Slow heart beat

High blood pressure

Low blood pressure

Poor circulation

Swelling of ankles

Previous heart attack

Previous stroke

**Urinary**

Painful urination

Bed-wetting

Frequent urination

Blood in urine

**Stress Symptoms**

Headaches

Migraines

Loss of sleep

Loss of concentration

Irritable/nervousness

Depression

Decreased energy

Tension

**Women Only**

Painful menstruation

Excessive flow

Irregular

Abnormal discharge

Birth control pill

Previous miscarriage

Menopausal

**Respiratory**

Chronic cough

Spitting up phlegm

Spitting up blood

Chest pain

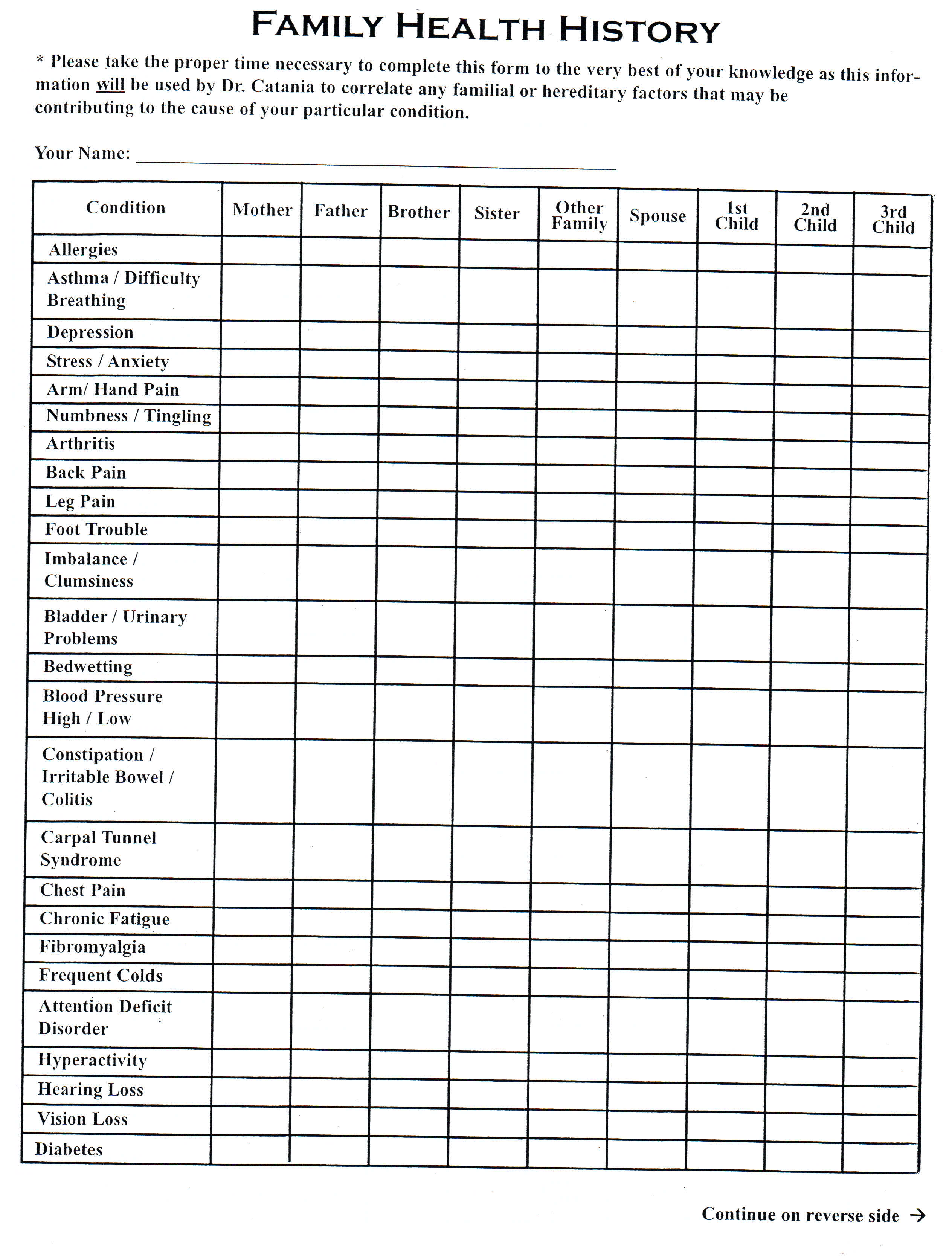
Asthma

Emphysema

Bronchitis

Croup

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