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### Patient Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone (Cell) \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F  
Marital Status M W D S Occupation/Employer \_\_\_\_\_ Phone  
(Work) \_\_\_\_\_  
Email \_\_\_\_\_  
Extended Health Insurance Company \_\_\_\_\_

Present condition due to an injury?  Yes  No  On the Job  Auto Accident  Other  
\_\_\_\_\_

Has the accident been reported?  Yes  No  To Employer  Auto Carrier  Other  
\_\_\_\_\_

### HEALTH REPORT:

Reasons for seeking care: (in order of severity)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

List any other types of doctors that you have seen for this:

\_\_\_\_\_

List any diagnosis and type of treatment: \_\_\_\_\_

Have you had similar accidents or injuries before?  Yes  No If yes, explain:

\_\_\_\_\_

Have you received chiropractic treatment previously?  Yes  No

If yes, explain: \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year?  Yes  No

If yes, explain: \_\_\_\_\_

Are you currently taking medication?  Yes  No list medications:

\_\_\_\_\_

\_\_\_\_\_

Have you taken medication in the past?  Yes  No list medications

\_\_\_\_\_

List conditions you are taking medications for:

\_\_\_\_\_

List the approximate dates of any surgery or treated  
conditions: \_\_\_\_\_

\_\_\_\_\_

Family History: Health conditions, age of death and cause of death.

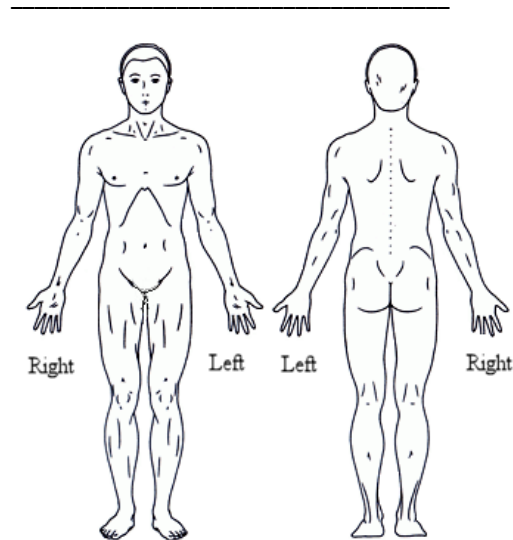
Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brother/s & Sister/s: \_\_\_\_\_

Do you smoke Y/N \_\_\_ •Alcohol Y/N \_\_\_Daily \_\_\_Weekly \_\_\_Social Occasions •Caffeinated drinks per day \_\_\_

Do you take Vitamins/Supplements Y/N If yes, type and how often



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness = = =

Dull Ache 000

Burning XXX

Sharp/Stabbing ///

Pins, Needles + + +

Other \_\_\_\_\_ ^ ^ ^

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your

condition/pain? \_\_\_\_\_

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with Work? \_\_\_\_\_

Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_

Is this condition progressively getting worse? \_\_\_\_\_

**Please mark each item below for each sign or symptom you presently have or previously had:**

**GENERAL SYMPTOMS**

\_\_\_ Convulsions

\_\_\_ Dizziness

\_\_\_ Fainting

\_\_\_ Headache

\_\_\_ Nervousness

\_\_\_ Numbness

\_\_\_ Wheezing

**MUSCLES & JOINTS**

\_\_\_ Low Back Problems

\_\_\_ Pain between Shoulders

\_\_\_ Neck Problems

\_\_\_ Arm Problems

\_\_\_ Leg Problems

\_\_\_ Swollen Joints

\_\_\_ Painful Joints

\_\_\_ Stiff Joints

\_\_\_ Sore Muscles

\_\_\_ Weak Muscles

\_\_\_ Walking Problems

\_\_\_ Sprains/Strains

\_\_\_ Broken Bones

**CARDIO-VASCULAR**

\_\_\_ High Blood Pressure

\_\_\_ Heart Attack

\_\_\_ Pain over Heart

\_\_\_ Poor Circulation

\_\_\_ Heart Trouble

\_\_\_ Rapid Heart

\_\_\_ Slow Heart

\_\_\_ Strokes

\_\_\_ Swelling Ankles

\_\_\_ Varicose Veins

**EAR/NOSE/THROAT**

\_\_\_ Earache

- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

**GASTRO-INTESTINAL**

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea

- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

**RESPIRATORY**

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

**GENITO-URINARY**

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems

- Loss of Bladder Control

**SKIN OR ALLERGIES**

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy \_\_\_\_\_

**FOR WOMEN ONLY**

- Birth Control \_\_\_\_\_
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please review each of these common stresses and circle when you experienced it in your life. Use **P for Past** and **C for Current**. If you expect or anticipate the possibility of experiencing this stress in the future, circle **F for Future**.

**Physical Stress is what we do to our bodies:**

**Comment:**

- |                                 |   |   |   |       |
|---------------------------------|---|---|---|-------|
| 1. Forceps delivery             | P | C | F | _____ |
| 2. Falls of any type            | P | C | F | _____ |
| 3. Broken bones                 | P | C | F | _____ |
| 4. Strains or sprains           | P | C | F | _____ |
| 5. Bad posture                  | P | C | F | _____ |
| 6. Poor sleeping habits         | P | C | F | _____ |
| 7. Repetitive movements         | P | C | F | _____ |
| 8. Sports injuries              | P | C | F | _____ |
| 9. Heavy lifting and/or bending | P | C | F | _____ |
| 10. Overweight                  | P | C | F | _____ |

**Chemical Stress is what we do to our organs:**

**Comment:**

- |  |   |   |   |       |
|--|---|---|---|-------|
| 1. Take prescription medication        | P | C | F | _____ |
| 2. Take over-the-counter drugs         | P | C | F | _____ |
| 3. Consume alcohol                     | P | C | F | _____ |
| 4. Consume caffeine                    | P | C | F | _____ |
| 5. Use tobacco products                | P | C | F | _____ |
| 6. Eat fast foods                      | P | C | F | _____ |
| 7. Use artificial sweeteners           | P | C | F | _____ |
| 8. Bad diet (white flour, white sugar) | P | C | F | _____ |
| 9. Exposed to environmental pollution  | P | C | F | _____ |
| 10. Overweight                         | P | C | F | _____ |

**Emotional Stress is what we do to our minds:**

**Comment:**

- |  |   |   |   |       |
|--|---|---|---|-------|
| 1. Divorce or parents or spouse        | P | C | F | _____ |
| 2. Death of a loved one                | P | C | F | _____ |
| 3. Serious illness (self or loved one) | P | C | F | _____ |
| 4. Financial concerns                  | P | C | F | _____ |
| 5. WORRY                               | P | C | F | _____ |
| 6. Work environment                    | P | C | F | _____ |
| 7. Relationships                       | P | C | F | _____ |
| 8. Anger by you or at you              | P | C | F | _____ |
| 9. Feel "not worthy"                   | P | C | F | _____ |
| 10. Put things off to the last minute  | P | C | F | _____ |

Chronic stress forms the foundation of many health problems. Which of the 3 types of stress has had the greatest impact on your health? \_\_\_\_\_