Dr. Mark Guker
Dr. Phil Sammut
1-2445 Eagle St N
Cambridge, Ontario N3H 4R7
(519) 650-1630 www.realignhealth.com

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:_____
_____

Dr. Mark Guker
Dr. Phil Sammut
1-2445 Eagle St N
Cambridge, Ontario N3H 4R7
(519) 650-1630 www.realignhealth.com

Patient Name: _____

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

Father: _____

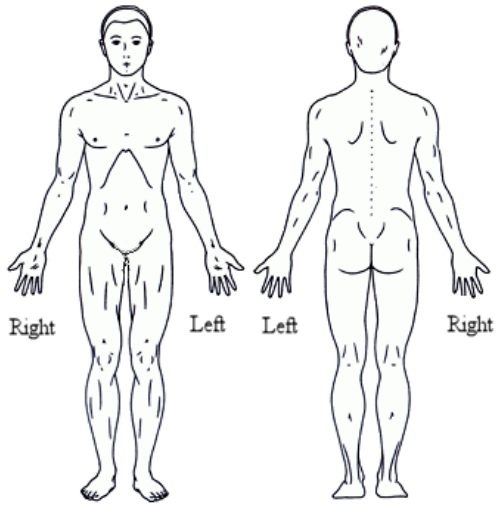
Mother: _____

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	OOO
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?_____

_____

Dr. Mark Guker
Dr. Phil Sammut
1-2445 Eagle St N
Cambridge, Ontario N3H 4R7
(519) 650-1630 www.realignhealth.com

Patient Name: _____

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_____