DR. CARLA M. WISEMAN DTCM Rac RMT

NAME: _____ DATE OF BIRTH _____ AGE: _____

EMAIL: _____

ADDRESS: _____ HEIGHT: _____ WEIGHT: _____ SEX: F M

_____ OCCUPATION: _____

_____ REFERRED BY: _____

PHONE # (H) _____ (W) _____ PHYSICIAN: _____

IN EMERGENCY NOTIFY: _____RELATIONSHIP: _____ PHONE: _____

MAIN PROBLEM: _____

WHEN DID THE PROBLEM BEGIN: _____ MEDICAL DIAGNOSIS: _____

MOTOR VEHICLE ACCIDENT?: YES __ NO __ DATE OF ACCIDENT: _____

ALLERGIES? (DRUGS, CHEMICALS, FOODS ETC.): _____

OCCUPATIONAL STRESS (CHEMICAL, PHYSICAL, PSYCHOLOGICAL): _____

MEDICATIONS: _____

SUPPLEMENTS: _____

ARE YOU ON A RESTRICTED DIET OR EXERCISE PROGRAM? _____

PLEASE DESCRIBE YOUR AVERAGE DIET: _____

HOW MANY MEALS DO YOU EAT A DAY? _____ DO YOU HAVE ANY CRAVINGS? _____

PLEASE CIRCLE THE PRODUCTS THAT ARE USED (CIGARETTES, ALCOHOL, DRUGS, COFFEE, TEA, SOFT DRINKS)

HOW OFTEN ARE THESE PRODUCT(S) USED A WEEK? _____

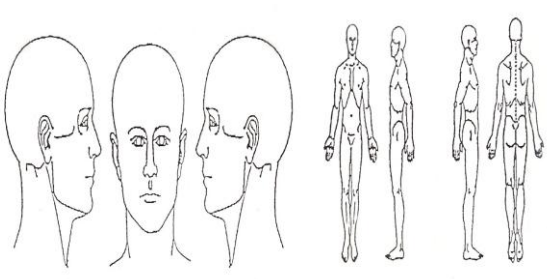
MEDICAL HISTORY

CANCER _____ HIV/AIDS _____ HEART DISEASE _____ DIABETES _____

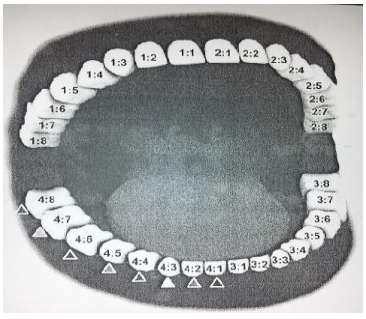
THYROID DISEASE _____ VENEREAL DISEASE _____ HEPATITIS _____

BLEEDING DISORDERS _____ HIGH/LOW BLOOD PRESSURE _____

INDICATE AREAS OF PAIN OR DISTRESS:



UPPER AND LOWER TEETH:



GENERAL:

- ❑ Any history of bleeding disorders
- ❑ Bleed or bruise easily
- ❑ Heart palpitations
- ❑ Shortness of breath
- ❑ Shortness of breath on exertion
- ❑ Recurrent infections
- ❑ Night sweats
- ❑ Sweating easily
- ❑ Edema
- ❑ Fatigue
- ❑ Sudden energy drop (time of day_____)
- ❑ Climate preference (warm/cold)
- ❑ Strong thirst (hot/cold)
- ❑ Thirst, no desire to drink
- ❑ Pain:where/type_____ _____ _____

Notes:

HEAD/EARS/EYES/NOSE/THROAT:

- ❑ Headaches
- ❑ Migraines
- ❑ Dizziness
- ❑ Ringing in ears
- ❑ Earache/Ear discharge
- ❑ Blurry vision
- ❑ Spots in front of eyes
- ❑ Eye dryness/pain
- ❑ Nasal discharge
- ❑ Nose bleeds
- ❑ Grinding teeth
- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Sores on lips/mouth
- ❑ Other _____

Notes:

DIGESTION:

- ❑ Heartburn
- ❑ Bad breath
- ❑ Nausea
- ❑ Vomiting
- ❑ Anorexia
- ❑ Bulimia
- ❑ Abdominal pain/cramps
- ❑ Feeling of heaviness after eating
- ❑ Gas
- ❑ Bloating
- ❑ Belching
- ❑ Constipation
- ❑ Loose stools
- ❑ Undigested food in stools
- ❑ Mucus in stools
- ❑ Blood in stools
- ❑ Strong smelling stools
- ❑ Rectal pain
- ❑ Fissures
- ❑ Hemorrhoids
- ❑ Other _____

Notes:

GENITO-URINARY:

- ❑ History of bladder/kidney infections
- ❑ Pain on urination
- ❑ Urgency with urination
- ❑ Frequent urination
- ❑ Blood in urination
- ❑ Decrease in urinary flow
- ❑ Unable to hold urine
- ❑ Incontinence at night
- ❑ Kidney stones
- ❑ Change in sexual drive
- ❑ Prostate problems
- ❑ Impotency
- ❑ Other

Do you wake up to urinate? Yes/No

How many times? _____

Notes:

SLEEP:

- ❑ Hours of sleep per night ____
- ❑ Quality of sleep_____
- ❑ Wake up at night
- ❑ Difficulty falling asleep
- ❑ Easily fall asleep
- ❑ Light sleeper
- ❑ Deep sleeper
- ❑ Wake up rested
- ❑ Nightmares
- ❑ Frequent dreams
- ❑ Other_____

Notes:

GYNECOLOGICAL:

# of Pregnancies _____ # of births _____ # premature births _____# of therapeutic abortions _____

Age of 1st menses_____

# of days between menses ____

Duration of menses _____

- ❑ Irregular periods
- ❑ Light periods
- ❑ Heavy period
- ❑ Clots
- ❑ Painful periods
- ❑ Unusual vaginal discharge
- ❑ Vaginal pain
- ❑ PMS
- ❑ Fibroids
- ❑ Breast lumps
- ❑ Endometriosis
- ❑ Infertility

Age of menopause_____

Date of last PAP_____

Other_____

Do you practice birth control? Yes No

Are you pregnant? Yes No

Are you trying to become pregnant? Yes No Due Date?_____

NEUROLOGICAL/BEHAVIOURAL

- ❑ Stroke
- ❑ Paralysis
- ❑ Poor balance
- ❑ Poor memory
- ❑ Difficulty concentrating
- ❑ Irritability
- ❑ Aggressive/bad temper
- ❑ Anxiety
- ❑ Depression
- ❑ Panic attacks
- ❑ Other_____

Did you wear braces? Yes ___ No __

Nightguard past/present? Yes ___ No __

Any teeth/tooth pulled? Yes ___ No __

TONGUE: _____ PULSE: _____

By my signature below, I authorize collection, use and disclosure of personal information, as defined in the Personal Information and Privacy Act (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential and must be treated in accordance with PIPA.

In consideration to your fellow patient and therapists,
24 hours notice of cancellation must be given, or a fee will be charged.

Signature _____ Date_____