



Dr. Matthew Hannikainen D.C.
69 Yonge Street, Suite 301 Toronto, ON M5E 1K3
Office: (416) 504-8880 Fax: (416) 504-7757

Confidential Patient Health Questionnaire

Thank you for choosing our office!

Name: Today's Date:
Date of Birth: (dd/mo/yr) Sex: Male / Female Age:
Address: City: Postal Code:
Phone: (H) (B): Ext. (M):
E-mail: Preferred method of contact:
Occupation: Number of children: Ages: M.D. Name
Who may we thank for referring you to our office?
Have you seen a chiropractor before? Yes No When?

About Your Health

You were born to be healthy! Everything you need to keep your body healthy and functioning properly is inside your brain. Your brain controls every single function in your body and it uses your nervous system to communicate to your body to keep it healthy. Spinal misalignments (Subluxations) or spinal damage can put pressure onto your nervous system and interfere with your brain's ability to keep your body functioning properly.

Health Questionnaire

- 1a. Reason for your visit today Wellness check-up OR A specific health concern?
b. What is your major complaint today? Please describe:
c. Is the condition interfering with Work Sleep Hobbies Mobility All of the above
d. Have you consulted anyone else for this condition? Yes No If yes, who
e. Have you tried anything to get rid of this problem? Yes No

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**What other symptoms have you experienced in the last 6 Months?**

- Headaches - Migraines, Pins & Needles in Leg / Arm (R) / (L), Constipation, Sleeping problems, Numbness in toes, Cold sweats, Back pain, Stomach Issues (upset), Diarrhea, Neck pain, Dizziness, Stiffness, Knee pain (R) (L), Shortness of breath, Loss of taste, Nervousness, Fatigue, Loss of smell, Tension, Depression, Loss of hearing, Irritability, Loss of memory, Ringing Ears, Chest pain, Loss of balance, Cold Hands, Fever, Fainting, Cold Feet

**ADDITIONAL INFORMATION:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Your Birth Process** (Please fill out to the best of your knowledge)

- Was your delivery long? \_\_\_\_\_
- Was your delivery difficult? \_\_\_\_\_
- Forceps / Vacuum extraction / Caesarean? \_\_\_\_\_
- Breach / Cephalic? \_\_\_\_\_
- Home / Hospital birth? \_\_\_\_\_
- Mother given drugs during delivery? \_\_\_\_\_
- Was labor induced? \_\_\_\_\_

**3. Growth & Development** (Please fill out to the best of your knowledge)

- Were you breast fed? \_\_\_\_\_
- Childhood sickness? \_\_\_\_\_ Explain \_\_\_\_\_
- Accidents? \_\_\_\_\_
- Surgery? \_\_\_\_\_ Explain: \_\_\_\_\_
- Drugs / Vaccines? \_\_\_\_\_
- Any falls? \_\_\_\_\_
- Do you have other traumas? What? \_\_\_\_\_  
When? \_\_\_\_\_

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4. Current Health Habits

Did / do you smoke? [ ] Yes [ ] No
Diet (do you eat healthy foods) [ ] Yes [ ] No
Regular exercise? [ ] Yes [ ] No
Have you been involved in any car accidents? [ ] Yes [ ] No [ ] When \_\_\_\_\_
Have you had surgery, organs removed or replaced? [ ] Yes [ ] No \_\_\_\_\_
Do you take prescription or non-prescription drugs? [ ] Yes [ ] No
If yes, please list and dosage frequency \_\_\_\_\_
Supplements? Please list \_\_\_\_\_
Teeth problems? \_\_\_\_\_ Hearing Problems? \_\_\_\_\_
Eye problems? \_\_\_\_\_ Glasses / Contacts: \_\_\_\_\_
Sleeping posture (back, side, stomach ) \_\_\_\_\_ (Nightmares? Insomnia?) \_\_\_\_\_
Physical stress? \_\_\_\_\_ Mental stress? \_\_\_\_\_
Hobbies / Sports injuries? \_\_\_\_\_

5. Please list 3 activities you would like to regain in your life?

\_\_\_\_\_
\_\_\_\_\_

6. What are your expectations from your treatment here, if you were to be accepted to start care?

\_\_\_\_\_
\_\_\_\_\_

About Your Care

Chiropractic provides three types of care. The first is Initial Intensive Care, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. The second stage of care is the Reconstructive Care. It is at this stage, years of damage that occurred on your spine is corrected. The last stage is Wellness Care. This is continued care to keep your body as healthy as possible. This will all be explained to you at your report of findings at which you will be able to begin a course of care that fits your health goals.

Consultation & Examination Fees

Table with 2 columns: Service, Fee. Rows: Consultation (Complimentary), Examination (\$150.00), Adjustments (\$55.00)

X-Rays

Table with 2 columns: Category, Fee. Rows: Ontario Residents (Covered by OHIP), Canadian Citizens - Other Provinces (Reciprocal Billing), Without a Health Card (\$495.00)

I have read the above fees for services and understand that I am responsible for the payment of all fees and services.

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

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