Chousky Centre
Innovative Treatment Powerful Results

951 Wilson Avenue, Unit 18L
Toronto, Ontario, M3K 2A7
416-222-3475

TELL US ABOUT YOU (Please print clearly)

Name:			Date:	
Date of Birth:	Age:	Sex: M F	Marital Status MS DW	# of children:
Address:				
City:		Province:	Postal code:	
Home Phone #:		Cell #:		
E-mail Address:				
Spouse's Name:				
Occupation (Current or Previous)			Retired: Y N	
Current or Previous Work	Clerical: Y N	Light Labor: Y N	Moderate Labor: Y N	Heavy Labor: Y N
In Case of Emergency Contact		Phone #		

TELL US ABOUT YOUR PAST HEALTH:

Y	N	Lower Back Pain	Y	N	Diabetes (A1C =_____)	Y	N	High Cholesterol
Y	N	Leg or Foot Pain/Numbness	Y	N	Hand Problems	Y	N	Shingles
Y	N	Prior Spinal Surgeries	Y	N	Neuropathy	Y	N	Cancer – Chemotherapy
Y	N	Spinal Fractures	Y	N	Heart Attack	Y	N	Kidney issues or Dialysis
Y	N	Spinal Stenosis	Y	N	Heart Problems	Y	N	Gout
Y	N	Spinal Arthritis	Y	N	High / Low Blood Pressure	Y	N	Knee / Hip / Foot Surgery
Y	N	Sciatica	Y	N	Vascular Leg Problems	Y	N	Leg Fractures
Y	N	Neck Pain	Y	N	Vascular Surgery	Y	N	Joint Replacement
Y	N	Herniated Disc	Y	N	Stroke	Y	N	Plantar Fasciitis

TELL US ABOUT ANY MEDICATIONS YOUR CURRENTLY ARE TAKING OR HAVE PREVIOUSLY TAKEN:

Y	N	LIPITOR (Atorvastatin)	Y	N	ZETIA (Ezetimibe)	Y	N	CYMBALTA (Duloxetine)
Y	N	CRESTOR (Rosuvastatin)	Y	N	HYDROCHLOROTHIAZIDE	Y	N	ELAVIL (Amitriptyline)
Y	N	ZOCOR (Simvastatin)	Y	N	BLOOD PRESSURE MEDS	Y	N	EFFEXOR (Venlafaxine)
Y	N	ALTOCOR (Lovastatin)	Y	N	LYRICA (Pregabalin)	Y	N	OXYCONTIN (Oxycodone)
Y	N	MEVACOR (Lovastatin)	Y	N	NEURONTIN (Gabapentin)	Y	N	LIDODERM PATCH
Y	N	LESCOL (Fluvastatin)	Y	N	TRILEPTAL (Oxocarbaziine)	Y	N	CAPSAICIN (Zostrix)
Y	N	PRAVACHOL (Atorvastatin)	Y	N	TOPAMAX (Topiramate)	Y	N	OVER THE COUNTER MEDS

PLEASE LIST ANY **OTHER MEDICATIONS** YOU ARE CURRENTLY TAKING, BUT ARE NOT LISTED ABOVE:

PLEASE LIST ANY **VITAMINS** YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY **SERIOUS MEDICAL CONDITIONS** YOU HAVE HAD:

NAME OF YOUR **PRIMARY CARE PHYSCIAN**:

PLEASE LIST BELOW ANY **BACK** OR **LEG SURGERIES** YOU'VE HAD:

HAVE YOU HAD AN **EMG** PERFORMED ON YOUR LEGS/FEET? NO	YES – WHEN?
DO YOU EXERCISE REGULAR? NO	YES – WHAT?

Dr. Cary M. Chousky D.C. 951 Wilson Avenue, Unit 18L, Toronto, Ontario M3K 2A7

REASON FOR THIS VISIT

WHAT KIND OF PROBLEM(S) ARE YOU HAVING:

ON A SCALE, HOW WOULD YOU RATE YOUR SYMPTOMS (10 is the worst) 1 2 3 4 5 6 7 8 9 10

WHEN DID THIS BEGIN:
WHAT MAKES IT BETTER:
WHAT MAKES IT WORSE:

ARE YOUR SYMPTOMS WORSE AT NIGHT? NO YES	IF YES, AROUND WHAT TIME?

HOW WOULD YOU DESCRIBE YOUR SYPMTOMS (Circle any that apply)							
	Stabbing-Sharp	Electric Shocks	Cold	Tingling	Pins & Needles	Dead Feeling	Throbbing
	Burning	Stings	Ache	Numbness	Swelling	Tiredness	Cramping

WHAT DO <u>YOU THINK</u> IS CAUSING YOUR PROBLEM:

IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING: (Circle any that apply)						
WORK	SLEEP	DAILY ROUTINE	CHORES	WALKING	STANDING	SHOPPING

REASON FOR THIS VISIT:

<u>How would you describe your average back/leg pain over the past week?</u>

NO PAIN **WORST PAIN**

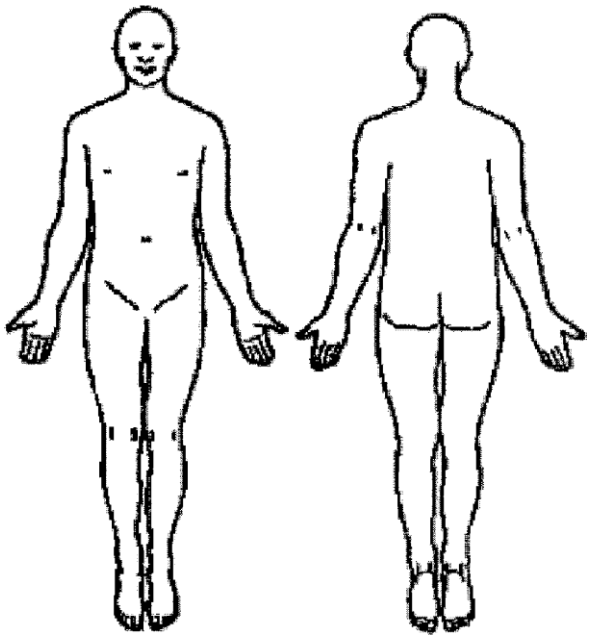
0 1 2 3 4 5 6 7 8 9 10

<u>Please indicate what you consider to be an acceptable level of pain after completion of the treatment if you have to accept some pain?</u>

NO PAIN **WORST PAIN**

0 1 2 3 4 5 6 7 8 9 10

Please indicate on these drawings, the body area(s) where you are currently experiencing symptoms:



TELL US ABOUT HOW THIS IS AFFECTING YOU:

What are your symptoms like at their **worst:**		
Is your **balance** or **walking ability** starting to be affected? N Y if yes, describe how and in what ways		
Which of the following is **true** for your condition: (check one of the following)		
It's getting better on it's own	It's staying the same	It's getting worst as time goes by
List any daytime activities (and **used to be able to do** when you were feeling better) that are now limited:		
List any "day-to-day" activities (**OK to do now**) that are getting harder and harder to do:		

A. I hereby authorize release of any medical information' necessary to evaluate my case or process any future claims.

B. I understand and agree that health policies are an arrangement between an insurance carrier and myself Therefore I understand that all future services are charged directly to me and agree to be personally responsible for payment

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

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Subjective Peripheral Neuropathy Screen Questionnaire

Full name:_____ **Date** _____

Phone Number:_____

Answer the following questions about the feeling in your hands, legs and/or feet. Check Yes or No based on how you usually feel. Thank you

1. Do you ever have hands, legs and/or feet that feel numb?	☐ Yes ☐ No
2. Do you ever have any burning pain in your hands, legs or feet?	☐ Yes ☐ No
3. Are your hands or feet too sensitive to touch?	☐ Yes ☐ No
4. Do you get muscle cramps in your legs and/or feet?	☐ Yes ☐ No
5. Do you ever have any prickling or tingling feelings in your hands legs or feet?	☐ Yes ☐ No
6. Does it hurt at night or when the covers touch your skin?	☐ Yes ☐ No
7. When you get into the tub or shower, are you unable to tell the hot water from the cold water with your feet?	☐ Yes ☐ No
8. Do you ever have any sharp, stabbing, shooting pain in your feet or legs?	☐ Yes ☐ No
9. Have you experienced an asleep feeling or loss of sensation in your legs or feet?	☐ Yes ☐ No
10. Do you feel weak when you walk?	☐ Yes ☐ No
11. Are your symptoms worse at night?	☐ Yes ☐ No
12. Do your legs and/or feet hurt when you walk?	☐ Yes ☐ No
13. Are you unable to sense your feet when you walk?	☐ Yes ☐ No
14. Is the skin on your feet so dry that it cracks open?	☐ Yes ☐ No
15. Have you ever had electric shock-like pain in your feet or legs?	☐ Yes ☐ No