Patient Information

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Email: _____
Business/Employer: _____ Type of Work: _____
Work Phone: _____ Birth date:_____ Age: _____ Sex: M F
Circle One: Married Single Widowed Divorced Separated Other Number Of Children: _____
Emergency Contact: _____ Phone Number: _____ Relationship: _____
How were you referred to this office? _____

Current Health Condition

Current Complaint(s): _____
Other doctors seen for this condition? Yes No Who? _____
Type Of Treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? _____
Is the condition: Job-related Auto-related Home Injury Fall Other: _____
Date of accident: _____ Time of Accident: _____
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _____
What relieves your condition? Bed Rest Ice Heat Massage Medication
Other: _____
Is it getting: Worse Better Constant Comes/Goes
Character of Pain: Sharp Dull Ache Pins & Needles Numb Burning
Constant Intermittent Other: _____
Place and X on the grade to indicate the severity of your pain:
Least 1 2 3 4 5 6 7 8 9 10 Worst
Drugs you take now: Nerve Pills Painkillers/Muscle Relaxers Blood Pressure Medicine
Insulin Other: _____
Do you suffer from any other condition than the one you are now consulting us for?_____
_____
Have you had x-rays taken in the last year? Yes No If yes, where? _____

Past Health History

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia
Back Surgery Broken Bones Other: _____
Previous: Childhood Traumas: _____ Sports Injuries: _____
Motor Vehicle Accidents: _____ Work Injuries: _____
Hospitalizations (other than above): _____
_____
Previous Chiropractic Care: None Doctor's Name: _____
Approximate Date of Last Visit: _____

Family Health History

Name of Family Physician: _____

Please indicate any health issues that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? No Yes Whom? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have had in the last six months:

Nervous System

☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Extremities
☐ Stress

Musculo-Skeletal

☐ Low Back Pain
☐ Gas/Bloating After Meals
☐ Pain Between Shoulders
☐ Heartburn
☐ Neck Pain
☐ Black/Bloody Stool
☐ Arm Pain
☐ Colitis
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficulty Chewing/Clicking Jaw
☐ General Stiffness

General

☐ Fatigue
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches

C-V-R

☐ Chest Pain
☐ Short breath
☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems
☐ Lung
☐ Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke

EENT

☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

Do you have a regular exercise program?

☐ Yes
☐ No

Lifestyle Stress Levels

☐ High

Low

Females Only

When was your last period**?**

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Intake

☐ Coffee
☐ Tea
☐ Alcohol
☐ Cigarettes

Satisfaction with Diet

☐ Highly Satisfied
☐ Dissatisfied
☐ Highly Dissatisfied