

Personal History

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Birth date: _____ Age: ____ Sex: M F O
E-mail _____
Business/Employer: _____ Business Phone: _____
Type of Work: _____
Circle One: Married Single Widowed Divorced Separated Other Number of Children: _____
Emergency Contact: _____ Phone Number: _____ Relationship: _____
Who may we thank for referring you 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 the condition occurred before? Yes No
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 Constant Comes/Goes Better
Character of Pain: Sharp Dull Ache Pins & Needles Numb Burning
 Constant Intermittent
Please describe how it feels when this problem is at its worse: _____

Place an X on the grade to indicate the severity of your pain:

LEAST 1 2 3 4 5 6 7 8 9 10 WORST

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:

Your ability to work? _____

Your ability to enjoy your family or your social time? _____

Your ability to enjoy your hobbies or sports? _____

At its worst, how old does this problem make you feel? _____

If you don't get the problem corrected, do you think it will get worse over the next 5 years? Yes No

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? _____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____

Have you had X-rays taken in the last six months? 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 _____

Hospitalization (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? _____

Have your children ever had a spinal check-up? No Yes If yes, where and when? _____

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 past 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
- Difficult 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

Gastro-Intestinal

- Poor / Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

Male / Female

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain / Infections
- Breast Pain / Lumps
- Prostate / Sexual Dysfunction

Genito-Urinary

- Bladder Trouble
- Painful / Excessive Urination
- Discolored Urine

Females Only

When was your last period?

Are you pregnant?

- Yes No Not Sure

Intake

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Satisfaction with Diet

- Highly Satisfied
- Dissatisfied
- Highly Dissatisfied

Do you have a regular exercise program?

- Yes
- No

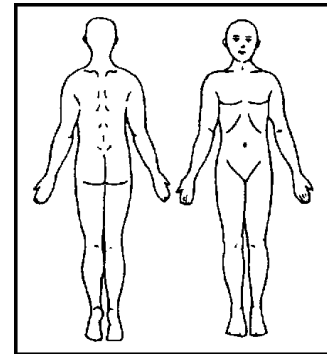
Lifestyle Stress Levels

- High
- Moderate
- Very Little

Check any of the following diseases you have had:

- Pneumonia
- Mumps
- Influenza
- Rheumatic Fever
- Small Pox
- Pleurisy
- Polio
- Chicken Pox
- Arthritis
- Tuberculosis
- Diabetes
- Epilepsy
- Whooping Cough
- Cancer
- Mental Disorder

- Anemia
- Heart Disease
- Lumbago
- Measles
- Thyroid
- Eczema



discomfort and any radiation of pain.

Please outline on the diagram the area of your

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- Preventative Care – Life Enhancement and Wellness Care
- Corrective Care – Removing Cause and Remodeling Soft Tissue
- Relief Care – Band-Aid Care Only
- Check here if you want the doctor to select the type of care appropriate for your condition.

Patient
Date

Signature