

# WESTMOUNT CHIROPRACTIC + MASSAGE

## **Personal History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone #: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Sex: Male  Female  Date of Birth (DD/MM/YY): \_\_\_\_\_ Age: \_\_\_\_\_

Emergency Contact Name and Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Alberta Health Care Number: \_\_\_\_\_

Occupation: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please describe your present complaint: \_\_\_\_\_

When did it occur: \_\_\_\_\_

How did it occur: \_\_\_\_\_

Have you received any treatment for this condition, and if so what kind of treatment?  
\_\_\_\_\_

Were x-rays taken? YES  NO

Have you been to a chiropractor before? Y / N When was your last treatment? \_\_\_\_\_

Was this an injury that occurred at work? Y / N Was it reported? Y / N

If yes name and phone number of company? \_\_\_\_\_

Was this an injury as a result of a car accident? Y / N If yes date of accident: \_\_\_\_\_

Do you currently smoke? Y / N

How often do you exercise? \_\_\_\_\_ times/week

Any prior surgeries/ hospitalizations? \_\_\_\_\_

Have you broken any bones? \_\_\_\_\_

Do you currently take any prescription or over the counter medications or vitamins/nutritional supplements?  
Specify: \_\_\_\_\_

## Health History

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	diabetes
<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	respiratory conditions	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	strokes
<input type="checkbox"/>	<input type="checkbox"/>	allergies	<input type="checkbox"/>	<input type="checkbox"/>	heart conditions	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	sleeping difficulties	<input type="checkbox"/>	<input type="checkbox"/>	pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	measles	<input type="checkbox"/>	<input type="checkbox"/>	mumps
<input type="checkbox"/>	<input type="checkbox"/>	mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	chicken pox			

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

### Nervous System

Current	Past	
<input type="checkbox"/>	<input type="checkbox"/>	nervous
<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	paralysis
<input type="checkbox"/>	<input type="checkbox"/>	dizziness
<input type="checkbox"/>	<input type="checkbox"/>	forgetfulness
<input type="checkbox"/>	<input type="checkbox"/>	confusion/depression
<input type="checkbox"/>	<input type="checkbox"/>	fainting
<input type="checkbox"/>	<input type="checkbox"/>	convulsions
<input type="checkbox"/>	<input type="checkbox"/>	cold/tingling
<input type="checkbox"/>	<input type="checkbox"/>	stress

### Musculo-Skeletal

<input type="checkbox"/>	<input type="checkbox"/>	low back pain
<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	ankle swelling
<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	sciatica
<input type="checkbox"/>	<input type="checkbox"/>	arm/shoulder pain
<input type="checkbox"/>	<input type="checkbox"/>	joint pain
<input type="checkbox"/>	<input type="checkbox"/>	walking problems
<input type="checkbox"/>	<input type="checkbox"/>	difficult chewing
<input type="checkbox"/>	<input type="checkbox"/>	clicking jaw
<input type="checkbox"/>	<input type="checkbox"/>	general stiffness

### Lifestyle Stress Levels

<input type="checkbox"/>	<input type="checkbox"/>	high
<input type="checkbox"/>	<input type="checkbox"/>	medium
<input type="checkbox"/>	<input type="checkbox"/>	very little

### General

Current	Past	
<input type="checkbox"/>	<input type="checkbox"/>	fatigue
<input type="checkbox"/>	<input type="checkbox"/>	allergies
<input type="checkbox"/>	<input type="checkbox"/>	loss of sleep
<input type="checkbox"/>	<input type="checkbox"/>	fever
<input type="checkbox"/>	<input type="checkbox"/>	headaches

### C-V-R

<input type="checkbox"/>	<input type="checkbox"/>	chest pain
<input type="checkbox"/>	<input type="checkbox"/>	short breath
<input type="checkbox"/>	<input type="checkbox"/>	irregular heartbeat
<input type="checkbox"/>	<input type="checkbox"/>	heart problems
<input type="checkbox"/>	<input type="checkbox"/>	lung problems
<input type="checkbox"/>	<input type="checkbox"/>	varicose veins

### EENT

<input type="checkbox"/>	<input type="checkbox"/>	vision problems
<input type="checkbox"/>	<input type="checkbox"/>	dental problems
<input type="checkbox"/>	<input type="checkbox"/>	sore throat
<input type="checkbox"/>	<input type="checkbox"/>	ear aches
<input type="checkbox"/>	<input type="checkbox"/>	hearing difficulties
<input type="checkbox"/>	<input type="checkbox"/>	stuffed nose

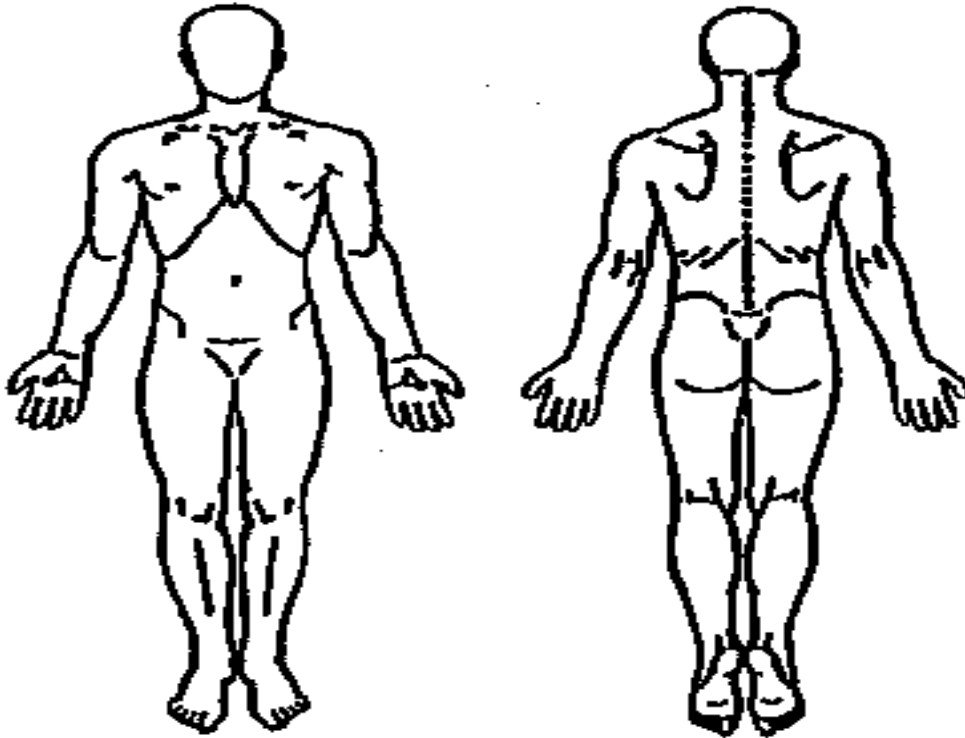
### Gastro-Intestinal

Current	Past	
<input type="checkbox"/>	<input type="checkbox"/>	poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>	frequent nausea
<input type="checkbox"/>	<input type="checkbox"/>	vomiting
<input type="checkbox"/>	<input type="checkbox"/>	diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	constipation
<input type="checkbox"/>	<input type="checkbox"/>	haemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	liver problems
<input type="checkbox"/>	<input type="checkbox"/>	gall bladder problems
<input type="checkbox"/>	<input type="checkbox"/>	weight trouble
<input type="checkbox"/>	<input type="checkbox"/>	abdominal cramps
<input type="checkbox"/>	<input type="checkbox"/>	heartburn
<input type="checkbox"/>	<input type="checkbox"/>	gas after meals
<input type="checkbox"/>	<input type="checkbox"/>	colitis

### Women Only

<input type="checkbox"/>	<input type="checkbox"/>	cramps
<input type="checkbox"/>	<input type="checkbox"/>	heavy flow
<input type="checkbox"/>	<input type="checkbox"/>	light flow
<input type="checkbox"/>	<input type="checkbox"/>	irregular cycle
<input type="checkbox"/>	<input type="checkbox"/>	painful cycle
<input type="checkbox"/>	<input type="checkbox"/>	discharge
<input type="checkbox"/>	<input type="checkbox"/>	sore breasts

Show the area(s) of pain or unusual feeling. Mark the areas on this body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.



Numbness                      •••

Pins & Needles                      ooo

Burning                      xxx

Aching                      \*\*\*

Stabbing                      ///

**Please 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

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my health.  
I agree to allow this office to examine me for further evaluation.

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

Patient's Name: \_\_\_\_\_

Witness's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_