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	
☐	☐	aneurysm	☐	☐	osteoporosis	☐	☐	diabetes
☐	☐	arthritis	☐	☐	respiratory conditions	☐	☐	epilepsy
☐	☐	cancer	☐	☐	high blood pressure	☐	☐	strokes
☐	☐	allergies	☐	☐	heart conditions	☐	☐	hepatitis
☐	☐	thyroid condition	☐	☐	fatigue	☐	☐	polio
☐	☐	sleeping difficulties	☐	☐	pneumonia	☐	☐	psoriasis
☐	☐	whooping cough	☐	☐	measles	☐	☐	mumps
☐	☐	mental disorder	☐	☐	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	
☐	☐	nervous
☐	☐	numbness
☐	☐	paralysis
☐	☐	dizziness
☐	☐	forgetfulness
☐	☐	confusion/depression
☐	☐	fainting
☐	☐	convulsions
☐	☐	cold/tingling
☐	☐	stress

Musculo-Skeletal

☐	☐	low back pain
☐	☐	neck pain
☐	☐	ankle swelling
☐	☐	neck pain
☐	☐	sciatica
☐	☐	arm/shoulder pain
☐	☐	joint pain
☐	☐	walking problems
☐	☐	difficult chewing
☐	☐	clicking jaw
☐	☐	general stiffness

Lifestyle Stress Levels

☐	☐	high
☐	☐	medium
☐	☐	very little

General

Current	Past	
☐	☐	fatigue
☐	☐	allergies
☐	☐	loss of sleep
☐	☐	fever
☐	☐	headaches

C-V-R

☐	☐	chest pain
☐	☐	short breath
☐	☐	irregular heartbeat
☐	☐	heart problems
☐	☐	lung problems
☐	☐	varicose veins

EENT

☐	☐	vision problems
☐	☐	dental problems
☐	☐	sore throat
☐	☐	ear aches
☐	☐	hearing difficulties
☐	☐	stuffed nose

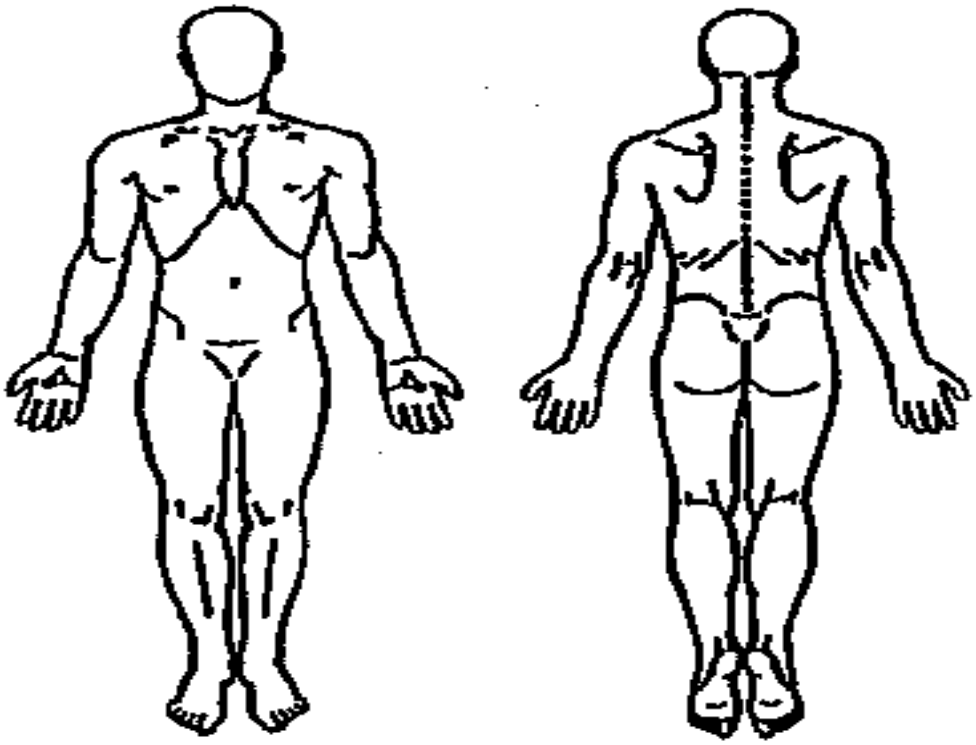
Gastro-Intestinal

Current	Past	
☐	☐	poor appetite
☐	☐	excessive thirst
☐	☐	frequent nausea
☐	☐	vomiting
☐	☐	diarrhea
☐	☐	constipation
☐	☐	haemorrhoids
☐	☐	liver problems
☐	☐	gall bladder problems
☐	☐	weight trouble
☐	☐	abdominal cramps
☐	☐	heartburn
☐	☐	gas after meals
☐	☐	colitis

Women Only

☐	☐	cramps
☐	☐	heavy flow
☐	☐	light flow
☐	☐	irregular cycle
☐	☐	painful cycle
☐	☐	discharge
☐	☐	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:**_____