*We are pleased to welcome you to our practice. Please take a few minutes to fill this form out **completely**.*
We look forward to working with you in enhancing & maintaining your health.

Name_________________________________ Age ____ Health Card #_______________ *Date*______________

Address______________________________ City ______________________ Province ___ Postal Code___________

Home Phone (___)_____________ Cell (___)______________ Work (___)_______________

Email ______________________________ May we **e-mail** you? __ Y __ N (appointment reminders & newsletters)

Birth Date _________________ Sex: M F Marital Status: S M D W Occupation _______________________

Doctor's Name: ____________________ Last Seen? ________________ Purpose: ________________________________

Who may we thank for referring you? _______________________

Why This Form is Important

*As a full spectrum Chiropractic office, our goals are, **first**, to address the issues that brought you to this office, and **second**, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we all experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: **not even felt until they become serious**. Answering the following questions will give us a profile of specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.*

Have you ever been to a Chiropractor for treatment? __Y __N If Yes, when & why?_______________________
____

Reason for this visit? __ no complaints __ wellness/spinal check- up __ specific concern

Specific Concern, describe:____

Are you here for: __ Correction of the causes of your health concern? OR __ Temporary/patch (relief) care?

Date the symptom(s) began? ______________ Have you had similar conditions?: __Y __N If yes, please explain:

____

How did it **start**? ____

What makes it **worse**? ____

What makes it **better**? ____

Describe your symptom: __Sharp __Dull __Throbbing __ Burning __Aching __Stabbing __ Other

Does your symptom **radiate** or travel to another place in your body? __ Y __ N If yes, describe: ___________________

____

Is your pain getting?: __ Worse __ Better __ Same __ Comes & goes

How frequently do you experience your symptoms? __ Constant __ Occasional

Who have you seen for this? ________________________ What did they do?________________________________

Does this complaint interfere with your?: __ work __ sleep __ personal life __mood __ activities

Are your present problem(s) due to an injury? __Y __N If yes, Date of injury: ____________________________

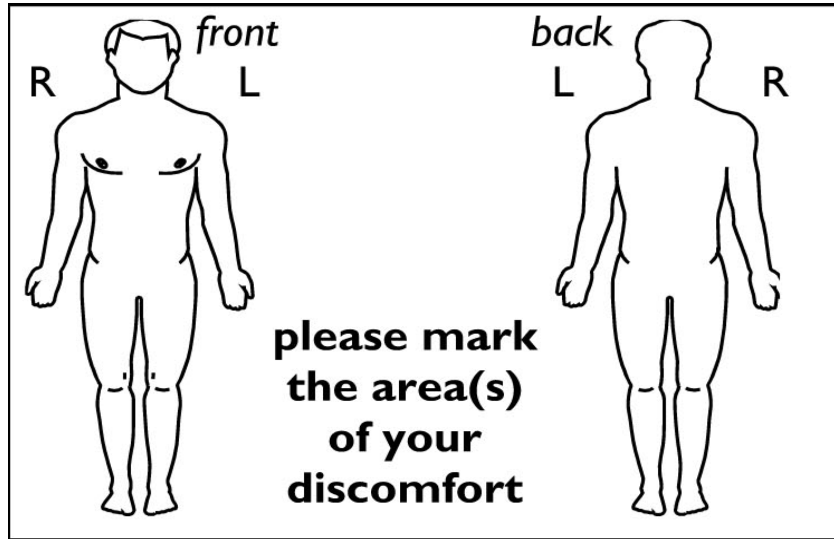
Was the injury? __ Job Related __Auto Accident __ Personal Injury __ Other

Please note that this office does NOT accept WCB cases.

Has the injury/accident been reported? __Y __N If so, to whom? __ Employer __ Auto Carrier __ MD

Describe: ________________________________ Tests &/or medications received:__________________________________

Please mark the illustration below where you are experiencing issues



Admitted to the hospital?: __Y __N If yes, Hospital:_________________________ Length of Stay ______________

Transported by: __ Ambulance __ Police __Other Date Admitted: ____________ Date Released: _____________

Do you have any current work restrictions related to this condition? __Y __N Off work? __ Y __ N From _______ To ________ Light Duty? __Y __N If yes, what were the restrictions?_____________________________________

Have you **ever** been in an **auto accident**? __Y __N When? _______________ Describe: ____

Have you **ever** had **X-rays** taken? __Y __N Reason & Date:___________________________________

Do you sleep well? __Y __N Position? __Back __Stomach __ Side How many bowel movements per day? _______

WOMEN only: Are you pregnant? __Y __N If, No: Last Menstrual Date: _____________
If, Yes: Due Date: ______________

HABBITS

__Smoking (packs/day) ___
__Alcohol (cups/day) ___
__ Coffee (cups/day) ___
__ Soft drinks (cans/day) ___
__ Water (cups/day) ___

EXERCISE

__ None
__ Moderate
__ Heavy

FAMILY HISTORY

	Diabetes	Cancer	Heart	Back Pain	Other
Mother	___	___	___	___	___
Father	___	___	___	___	___
Siblings	___	___	___	___	___
Children	___	___	___	___	___

SUPPLEMENTS: (list) ____

MEDICATIONS: (list) ____

Allergies (including drugs): ____

Drugs taken in the last year: __ Pain Killers __ Muscle Relaxants __ Corticosteroids __ Anti-Coagulants/Blood Thinners

List surgical operations & years: ____

Check all that apply to you.

General Symptoms	*Gastro-intestinal*	*Eye/Ear/Nose/Throat*	*Respiratory*	*Muscle and Joint*
__ Allergy	__Belching or Gas	__Asthma	__ Chest Pain	__ Neck pain/stiffness
__ Fatigue	__Constipation	__ Deafness	__Chronic Cough	__ Low Back pain
__ Headache	__Diarrhea	__ Earache	__Spitting Blood	__ Mid Back pain
__ Convulsions	__ Bloody Stools	__Ear Discharge	__ Spitting Phlegm	__Swollen joints
__Dizziness	__Gall Bladder	__ Ear Noises	__ Fainting	__ Foot or Knee pain
__ Hemorrhoids	__Frequent urination	__Nasal obstr.	__Wheezing	__Shoulder pain
__ Thyroid Prob.	__Blood in Urine	__Sinusitis	__Bronchitis	__ Hip pain
__Loss of Sleep	__ Painful Urination	__Nose Bleeds	__ Short of Breath	__ Faulty posture
__Nausea	__Stomach Pain	__ Pain in Eyes		__ Spinal Curvature
__ Loss of Weight	__Kidney Infection	__ Poor Vision		__ Arthritis
__ Nervousness	__Kidney Stones	__Blurred Vision		__Numbness ___________
__Night Sweats	__Heart Burn	__ Ringing the Ears		__ TMJ/Jaw pain
__ Stress/tension	__ Ulcers	__Loss of Smell		__ Cold Hands/Feet
__ Anxiety	__ Vomiting			__ Balance prob.
__ Depression	__ Vomiting Blood			__ Co-ordination
__ Mood Swings/Irritability				
__ High Blood Pressure				
__ Heart Problems/Stroke				

<u>**Females Only**</u>: __ Painful cycles __Irregular Cycles
__ Hot Flashes __ Menopause __ PMS/Menstrual Cramps

Do you have OR have you had any of the following?

__Appendicitis	__Anemia	__Heart Disease	__Arthritis	__Pneumonia
__Measles	__Goiter	__ Rheumatic fever	__ Epilepsy	__Mumps
__Influenza	__Polio	__Mental Disorder	__Pleurisy	__Chicken Pox
__Lumbago	__Diabetes	__Tuberculosis	__ Eczema	__Alcoholism
__Cancer	__VD	__Whooping Cough	__HIV Positive	__ Stroke/TIA

Patient's/Guardian's **Signature**: ___________________________________ Date: _______________