Movement Chiropractic

7-3602 Taylor Street East
Saskatoon, SK S7H 5H9

CHIROPRACTIC CONFIDENTIAL PATIENT HISTORY

NAME:_____ DATE:_____

ADDRESS:_____ CITY/TOWN: _____

PROV: _____ POSTAL CODE:_____ PHONE: _____

WORK PHONE: _____CELL PHONE:_____ PHN#_____

BIRTHDATE: DD/____MM/____YY/____ AGE: _____OCCUPATION:_____

EMAIL: _____Email Appointment Reminders? ☐ Yes ☐ No

HOW DID YOU HEAR ABOUT OUR CLINIC? ☐ WEBSITE ☐ GOOGLE ☐ REFERRED BY: _____

Please complete this questionnaire.
Your answers will help us determine if chiropractic care can help you. Thank You.

Is this a SGI Claim? ☐ Yes ☐ No
If so, Claim #_____ Adjustor:_____Accident Date: _____

Is this a WCB Claim? ☐ Yes ☐ No
If so, Claim #_____Case Manager:_____Injury Date:_____

Have you had previous chiropractic care? ☐ Yes ☐ No If so, when?_____

For what condition?_____

Medical Doctor:_____ Last Physical:_____

Please indicate medications that you take or have taken in the past year:
☐ Pain Killers ☐ Aspirin ☐ Muscle Relaxants ☐ Birth Control pills ☐ Corticosteriods
☐ Anti-coagulants/blood thinners ☐ Other_____

List surgical operations and Years:_____

Have you: **Been in an accident?** ☐ Yes ☐ No If so, please describe:_____

Had x-rays taken of your spine? ☐ Yes ☐ No If so, when?_____

Do you: **Smoke?** ☐ Yes ☐ No If so, how much?_____

Participate in a regular exercise program? ☐ Yes ☐ No If so, please describe:_____

Are you pregnant? ☐ Yes ☐ No If so, how many weeks?_____

Please check all that apply:

CONDITION	Past	Present	Family History	CONDITION	Past	Present	Family History
Arthritis				Hearing Loss			
Asthma				Heart Disease			
Backache				High Blood Pressure			
Cancer				High Cholesterol			
Chest Pain				Shortness of Breath			
Diabetes				Stroke			
Dizziness/Fainting				Transient Ischemic Attack			
Gastrointestinal Problems				Vision Problems			
Headaches				Other:			

As a chiropractic office, we focus on your potential to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness care in the future. The following information addresses the health concerns that brought you to our office.

If you have no symptoms or complaints and are here for wellness care, please check here □
If not please complete the following questions.

Reason for consulting the clinic:_____

_____

How long have you had your primary complaint?_____

How did it start?_____

_____

Is there anything that makes it better? (e g. rest, medication, ice, heat)_____

_____

Is there anything that makes it worse? (e. g. lifting, standing, sitting)_____

_____

Please describe what activities you do on a daily basis (e. g. lifting, prolonged standing or sitting…..)_____

_____

_____

Have you had any of the following regarding your present condition?

□ Medical Examination □ Chiropractic Care □ Massage Therapy □ Physiotherapy
□ Specialist □ Naturopathic Physician □ Acupuncture □ Other_____

Please mark on the diagrams below, your areas of pain/discomfort:

Height:_____ Weight:_____