

**Southside Chiropractic and Health Centre: Dr. Don MacDonald/Dr. Kurtis Fischer**

7906 B 104 Street, Edmonton, AB T6E 4C8

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## Confidential Life History-MALES

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

Please complete the following questionnaire. Your answers will help us to determine if Chiropractic can help you. Thank you!

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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

Home Telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

TEXT OR EMAIL REMINDERS? YES- text or email? Cell provider: \_\_\_\_\_ NO

Alberta Healthcare #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Name of Business: \_\_\_\_\_

Emergency Contact Name and number: \_\_\_\_\_

Referred By: \_\_\_\_\_

### Claim Will Be Made Against:

1. Recent motor vehicle accident?  Yes  No

2. Work related injury/accident (WCB)?  Yes  No WCB # \_\_\_\_\_

### Loss of Health Information:

Reason for attending office: \_\_\_\_\_

Location of pain if experiencing pain \_\_\_\_\_

When did you notice it? \_\_\_\_\_ How often does it occur? \_\_\_\_\_

Does it radiate?  Yes  No If yes, where? \_\_\_\_\_

What relieves it? \_\_\_\_\_

What aggravates it? \_\_\_\_\_

Describe how it interferes with your life, work, or hobbies: \_\_\_\_\_

When have you had this or similar conditions in the past? \_\_\_\_\_

Is condition getting worse?  Yes  No  Constant  Comes and Goes

Have you had previous Chiropractic care?  Yes  No

Where? \_\_\_\_\_ When? \_\_\_\_\_

Why? \_\_\_\_\_ Were x-rays taken?  Yes  No

Other treatments tried: \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

### Past Health History:

Please check if you presently have or have had any of the following conditions in the past:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Blurring of Vision  | <input type="checkbox"/> Bronchitis            | <input type="checkbox"/> Diarrhea      | <input type="checkbox"/> Insomnia             |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Tendonitis           |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Respiratory condition | <input type="checkbox"/> Heart Burn    | <input type="checkbox"/> Urinary Frequency    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pains           | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Lower Back Pain      |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Allergies     | <input type="checkbox"/> Numbness or Tingling |

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- |   |  |  |                                    |
|---|--|--|------------------------------------|
| <input type="checkbox"/> Aneurysm       | <input type="checkbox"/> Hiatus Hernia | <input type="checkbox"/> Sinusitis       | <input type="checkbox"/> Low drive |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Constipation  | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Fatigue   |

## Chronic Lifestyle Stressors

Any family health conditions:  Yes  No Please list: \_\_\_\_\_

Other health problems? \_\_\_\_\_

List surgical operations or hospitalizations and years they occurred: \_\_\_\_\_

List of medications you now take: \_\_\_\_\_

List and describe any auto accidents or other accidents/injuries: \_\_\_\_\_

List and describe any childhood injuries/accidents/hospitalizations/illnesses: \_\_\_\_\_

Anything else you feel we should know about? \_\_\_\_\_

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

Numbness                   ● ● ● ● ●  
                                   ● ● ● ● ●  
                                   ● ● ● ● ●

Pins & Needles           ○ ○ ○ ○ ○  
                                   ○ ○ ○ ○ ○  
                                   ○ ○ ○ ○ ○

Burning                    X X X X X  
                                   X X X X X  
                                   X X X X X

Aching                     \* \* \* \* \*  
                                   \* \* \* \* \*  
                                   \* \* \* \* \*

Stabbing                   / / / / /  
                                   / / / / /

