Midnapore

Health Centre

107, 239 Midpark Way, SE, Calgary, AB, T2X 1M2 (403) 254-9277

Welcome. *We are a complimentary, alternative health centre, specializing in Chiropractic, Physiotherapy, Massage & Nutritional Counselling, emphasizing wellness based techniques & philosophies.*

Please take a few minutes to provide us with some information about yourself.

Name ______________________ Telephone: Home ______________

Address ______________________ Work ______________

____

Age _____ Birth Date ______________

Postal Code ______________________

Male _____ Female _____

Occupation ______________________

Employer ____

Referred to this office by: ______________________________________

Number of Children________ Married___Single___Widowed___Divorced___Separated___

Who is responsible for your account? ________ Self___Parent___Auto Insurance___

Alberta Health Care # ______________________________

3rd Party Insurance ____Company Name ______________________________

Workers Compensation __________ SIN# ______________________________

E-mail Address ______________________________

Would you like to receive appointment reminders _____ or our monthly newsletter _____via e-mail?

I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature: ______________________________ Date: ______________

Signature of Guardian
or Spouse Authorizing Care:______________________________ Date: ______________

"Pain Is Merely a Symptom...Adjust the Cause"

Midnapore

Chiropractic Clinic

107, 239 Midpark Way, SE, Calgary, AB, T2X 1M2 (403) 254-9177

WELCOME	*The purpose of our Chiropractic Clinic is to support each individual in achieving their optimum health and to educate them so that they may understand health and chiropractic and in turn educate others.*

Current Health Condition

Purpose of this appointment: ____

____

Other doctors seen for this condition: ______________________________________

____

When did this condition begin: ____

____

If disabled from work, please give dates: ____________________________________

____

Job related: ______ Work related: ______ Motor Vehicle Accident: ______

Have you ever received Chiropractic care? Yes___ No___

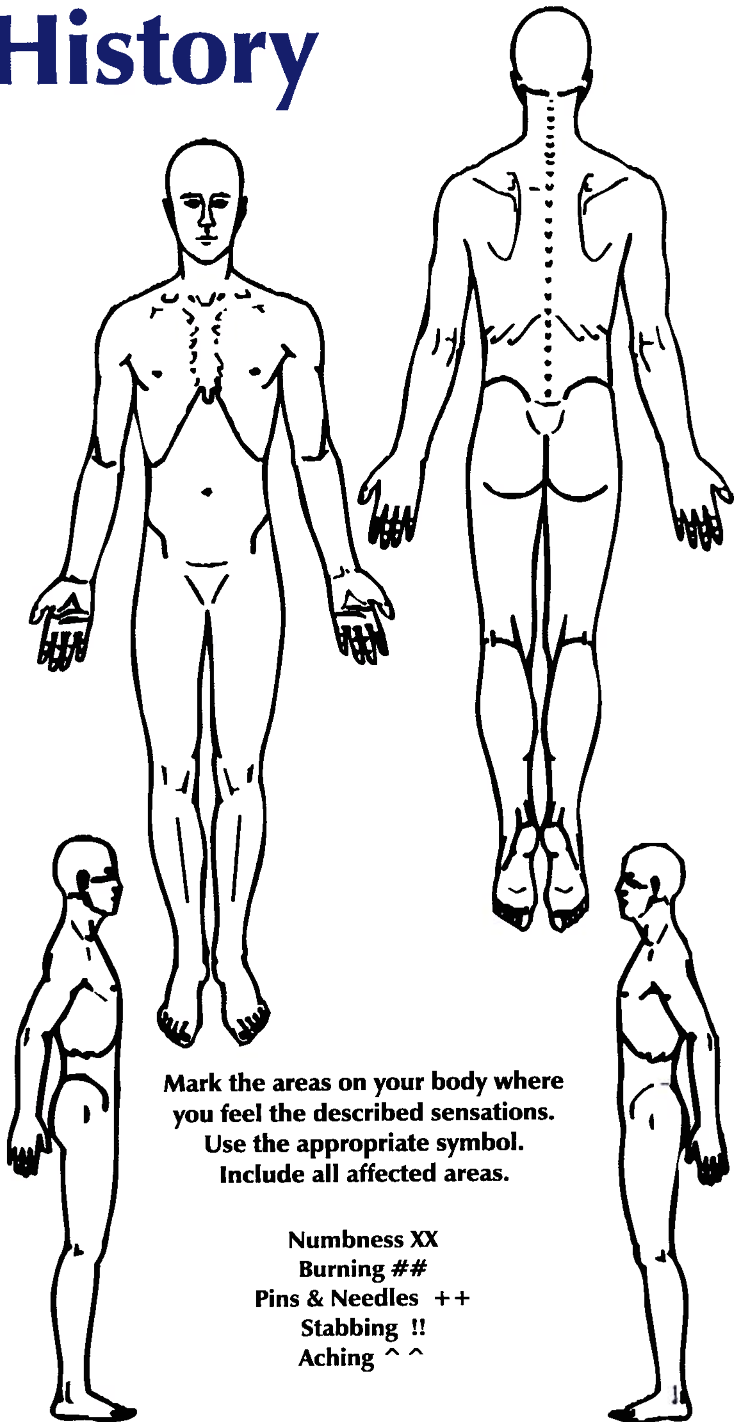
Why Chiropractic?

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort, ***(Relief Care)***. Others are interested in having the cause of the problem, as well as the symptoms corrected and relieved, ***(Functional/Rehabilitative Care)***. Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible, with Chiropractic care, ***(Wellness Care)***. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired, so that we may be guided by your wishes whenever possible.

☐ **Relief Care** ☐ **Rehabilitative Care** ☐ **Wellness Care** ☐ **Check here if you want the Doctor to select the type of care appropriate for your condition.**

Spinal Health History



Birth Process

YES	NO	NOT SURE	
☐	☐	☐	Were you a breach baby?
☐	☐	☐	Were forceps used?
☐	☐	☐	Was your Mother induced?
☐	☐	☐	Were you Cesarian?
☐	☐	☐	Was the delivery long or difficult?

Childhood/Adolescence

YES	NO	NOT SURE	
☐	☐	☐	Did you have colic?
☐	☐	☐	Did you suffer with ear infections?
☐	☐	☐	Any back or neck pain?
☐	☐	☐	Any broken bones?
☐	☐	☐	Were you taught how to care for your spine?

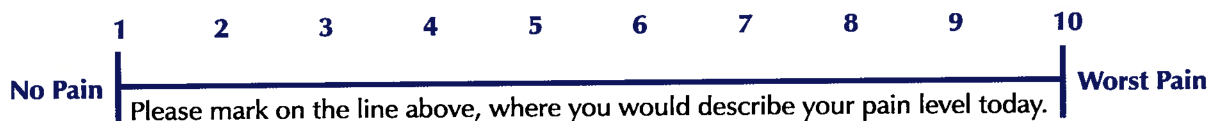
Adult Life

YES	NO	NOT SURE	
☐	☐	☐	Have you ever participated in contact sports?
☐	☐	☐	Do you currently partake in a regular exercise program to improve your health?
☐	☐	☐	Do you adequately control your stress?
☐	☐	☐	Have you ever been knocked unconscious?
☐	☐	☐	Have you ever had a severe fall or injury?
☐	☐	☐	Have you ever been in a motor vehicle accident, with or without injury?
☐	☐	☐	Have you ever been under treatment for cancer?
☐	☐	☐	Have you experienced any changes in weight in the last year?
☐	☐	☐	Do you take vitamins & nutritional products?
☐	☐	☐	Have you broken any bones?
☐	☐	☐	Have you been taught proper lifting and body mechanics?

Intake

MILD	MODERATE	
☐	☐	Coffee
☐	☐	Tea
☐	☐	Alcohol
☐	☐	Tobacco

MILD	MODERATE	
☐	☐	White Sugar
☐	☐	Pain Killers
☐	☐	Medications



Patient History

Please list any major accidents or falls:

Please list any hospitalizations:

Please Check Any Of The Following Problems You Have Had:

- ☐ Pneumonia
- ☐ Rhuematic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Sexually Transmitted Diseases
- ☐ Eczema

MUSCULO-SKELETAL

- ☐ Headaches
- ☐ Hip/Leg Pain
- ☐ Shoulder/Arm Pain
- ☐ Jaw Pain & Clicking
- ☐ Pain Between Shoulders
- ☐ Walking Problems
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ General Stiffness

MEDICATIONS

- ☐ Nerve Pills
- ☐ Muscle Relaxants
- ☐ Insulin
- ☐ Pain Killers
- ☐ Arthritis Pills
- ☐ Anti-depressants
- ☐ Anti-inflammatoriies
- ☐ Blood Pressure Pills
- ☐ Other

EARS, EYES, NOSE & THROAT

- ☐ Vision Problems
- ☐ Ear Aches
- ☐ Dental Problems
- ☐ Hearing Problems
- ☐ Frequent Sore Throat
- ☐ Sinus Congestion

SURGERIES

- ☐ Appendix
- ☐ Hysterectomy
- ☐ Tonsils
- ☐ Hernia
- ☐ Gall Bladder
- ☐ Other

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Convulsions
- ☐ Fainting
- ☐ Cold/Tingling Extremities
- ☐ Confusion/Forgetfullness
- ☐ Stress/Tension
- ☐ Paralysis
- ☐ Dizziness
- ☐ Depression

FEMALES ONLY

When was your last period?

....

Are you pregnant?

Yes.......No......Not Sure..............

- ☐ Menstrual Irregularity.
- ☐ Menstrual Cramps'
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps

CARDIOVASCULAR SYSTEM

- ☐ Heart Problems
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Lung Problems/Congestion
- ☐ Stroke
- ☐ Chest Pain
- ☐ Asthma
- ☐ Ankle Swelling
- ☐ Angina
- ☐ Shortness of Breath
- ☐ Varicose Veins

GASTRO-INTESTINAL

- ☐ Poor/excessive Appetite
- ☐ Frequent Nausea
- ☐ Hemorrhoids
- ☐ Gall Bladder Problems
- ☐ Gas/bloating After Meals
- ☐ Black/bloody Stool
- ☐ Excessive Thirst
- ☐ Diarrhea
- ☐ Liver Problems
- ☐ Abdominal Cramps
- ☐ Heartburn
- ☐ Vomiting
- ☐ Constipation
- ☐ Weight Problems
- ☐ Indigestion
- ☐ Colitis
- ☐ Unexplained Fever

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Discolored Urine
- ☐ Painful/escessive Urination
- ☐ Prostate/sexual Dysfunction

FAMILY HISTORY

The following family members have the same or similar problem as I do.

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child