

# Truro Chiropractic Clinic Inc.

File# \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Last name \_\_\_\_\_

Employer \_\_\_\_\_

First Name \_\_\_\_\_

Occupation \_\_\_\_\_

Salutation Mr \_\_\_ Mrs \_\_\_ Ms \_\_\_ Dr \_\_\_

Work address \_\_\_\_\_

Date of birth D \_\_\_ M \_\_\_ Y \_\_\_

Work phone(\_\_\_\_) \_\_\_\_\_

Marital status \_\_\_\_\_

Emergency Contact:

Spouse's name \_\_\_\_\_

Name \_\_\_\_\_

Child's name&age \_\_\_\_\_

Relationship \_\_\_\_\_

\_\_\_\_\_

Phone(\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_

Medical Doctor \_\_\_\_\_

\_\_\_\_\_

Health card# \_\_\_\_\_

Home address \_\_\_\_\_

City/town \_\_\_\_\_

How did you choose us for  
your health care?

Province \_\_\_\_\_

Postal code \_\_\_\_\_

Friend(name) \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_

Physician(name) \_\_\_\_\_

Cell phone (\_\_\_\_) \_\_\_\_\_

Yellow Pages \_\_\_\_\_ Sign \_\_\_\_\_

Which # should we try first? \_\_\_\_\_

Other \_\_\_\_\_

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Complete this area if visit is due to a WCB \_\_\_ or MVA \_\_\_ case:

Company name \_\_\_\_\_

Policy/Claim# \_\_\_\_\_

Contact name \_\_\_\_\_

SIN# \_\_\_\_\_

Phone # \_\_\_\_\_

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In order to help with diagnosis, please fill out the following so we may obtain your past or future x-ray reports:

I, \_\_\_\_\_, do hereby authorize the release to Dr. Joanna M. Christianson any diagnostic images, x-ray reports or impressions pertaining to me, and for doing so, let this be your good and sufficient authority.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Have you had chiropractic care? Y\_\_\_ N\_\_\_ Nature of present visit:  
Who? \_\_\_\_\_ Total health care \_\_\_\_\_  
Where? \_\_\_\_\_ Acute pain relief \_\_\_\_\_  
When? \_\_\_\_\_ Preventative care \_\_\_\_\_

What is your major complaint? \_\_\_\_\_ Other complaints? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_  
Have you been treated by any other practitioners for this condition? \_\_\_\_\_  
If so, by whom? \_\_\_\_\_  
Please list any and all surgical operations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been in a motor vehicle accident? \_\_\_\_\_  
When? \_\_\_\_\_  
Please list contributing factors to your present condition:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The information on our website will help you get well and stay well. By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website, and provide us with the following details so we can establish you as a member of our website today:

E-mail address \_\_\_\_\_

Please check the health subjects that most interest you:

- Headaches and neck pain
- Backaches and sciatica
- Children's health issues
- Exercise and fitness
- Diet and nutrition
- Stress management
- Wellness topics
- Women's health issues

**General Health Form:**

*√ for present problem*

*X for past problem*

<b>MUSCULO-SKELETAL</b>	<b>GASTRO-INTESTINAL</b>	<b>GENITO-URINARY</b>
<input type="checkbox"/> Low back problems <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Neck problems <input type="checkbox"/> Arm pain <input type="checkbox"/> Swollen joints <input type="checkbox"/> Leg pain <input type="checkbox"/> Stiff joints <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Walking problems <input type="checkbox"/> Ruptures (hernias) <input type="checkbox"/> Broken bones or fractures <input type="checkbox"/> Dislocations <input type="checkbox"/> Bone disease <input type="checkbox"/> Other _____	<input type="checkbox"/> Poor appetite <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heartburn <input type="checkbox"/> Excessive gas <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Frequent nausea <input type="checkbox"/> Frequent vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Ulcers <input type="checkbox"/> Irregular bowel movement <input type="checkbox"/> Intestinal infection <input type="checkbox"/> Indigestion <input type="checkbox"/> Red or tar coloured stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Frequent constipation <input type="checkbox"/> Weight trouble <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____	<input type="checkbox"/> Irregular urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Bladder infection <input type="checkbox"/> Excessive urination <input type="checkbox"/> Scanty urination <input type="checkbox"/> Discoloured urine <input type="checkbox"/> Weak bladder <input type="checkbox"/> Kidney stones <input type="checkbox"/> Prostate trouble <input type="checkbox"/> Other _____
<b>NERVOUS SYSTEM</b>		<b>EYES</b>
<input type="checkbox"/> Incoordination <input type="checkbox"/> Tremors <input type="checkbox"/> Loss of feeling <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Muscle twitching <input type="checkbox"/> Convulsions/seizures <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion <input type="checkbox"/> Depression <input type="checkbox"/> Other _____		<input type="checkbox"/> Pain <input type="checkbox"/> Blurring <input type="checkbox"/> Bothered by light <input type="checkbox"/> Infection <input type="checkbox"/> Loss of vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Other _____
	<b>CARDIOVASCULAR</b>	<b>EARS</b>
	<input type="checkbox"/> Chest pain <input type="checkbox"/> Racing heartbeat <input type="checkbox"/> Swelling of feet or ankle <input type="checkbox"/> Varicose veins <input type="checkbox"/> Fainting spells <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Cramps in legs <input type="checkbox"/> Poor circulation <input type="checkbox"/> Jaundice <input type="checkbox"/> Anemia <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____	<input type="checkbox"/> Pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Discharge from ears <input type="checkbox"/> Infection <input type="checkbox"/> Other _____
<b>FEMALES ONLY</b>		<b>Nose</b>
<input type="checkbox"/> Menopause <input type="checkbox"/> Discharge from nipples <input type="checkbox"/> Lumps in breast <input type="checkbox"/> Breast pain <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Abnormal menstruation <input type="checkbox"/> Painful menses <input type="checkbox"/> Contraceptives <input type="checkbox"/> # of pregnancies <input type="checkbox"/> # of children <input type="checkbox"/> Other _____		<input type="checkbox"/> Discharge <input type="checkbox"/> Sinus problems <input type="checkbox"/> Other _____
	<b>RESPIRATORY</b>	<b>Throat</b>
	<input type="checkbox"/> Constant cough <input type="checkbox"/> Excessive phlem(sputum) <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Other _____	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Enlarged glands
		<b>MOUTH</b>
		<input type="checkbox"/> Bite plane for TMJ <input type="checkbox"/> Gum disease <input type="checkbox"/> Swollen gums <input type="checkbox"/> Painful gums <input type="checkbox"/> Change in taste <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Other _____

SKIN	DISEASES	Medication
<input type="checkbox"/> Rashes <input type="checkbox"/> Lumps <input type="checkbox"/> Bruise easily <input type="checkbox"/> Other _____	<input type="checkbox"/> Cancer <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Chicken Pox <input type="checkbox"/> German measles <input type="checkbox"/> Whooping cough <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Diphtheria <input type="checkbox"/> Hip joint disease <input type="checkbox"/> Small pox <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Malaria <input type="checkbox"/> Polio <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Other _____	<input type="checkbox"/> Insulin <input type="checkbox"/> Antacid <input type="checkbox"/> Heartburn remedy <input type="checkbox"/> Laxative <input type="checkbox"/> Water pill <input type="checkbox"/> Aspirin <input type="checkbox"/> Muscle relaxant <input type="checkbox"/> Tranquilizer <input type="checkbox"/> Blood pressure pill <input type="checkbox"/> Birth control pill <input type="checkbox"/> Mega dose vitamin <input type="checkbox"/> Pain killer <input type="checkbox"/> Nerve pill <input type="checkbox"/> Pep pill <input type="checkbox"/> Narcotic <input type="checkbox"/> Anti-inflammatory <input type="checkbox"/> Other
ALLERGIES		
<input type="checkbox"/> Food _____ _____ <input type="checkbox"/> Feathers <input type="checkbox"/> Flowers or Pollen <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Perfume and scents _____ <input type="checkbox"/> Other _____ _____ _____ _____		
Habit	Frequency	Do you wear orthotics? Y__ N__
Coffee	___ cups per day	
Tea	___ cups per day	
Cigarettes	___ packs per week	
Alcohol	___ drinks per week	
Sleep	___ hours per night	

Provincial Health Care in Nova Scotia does not cover chiropractic health care services. Therefore payment is due at the time of services rendered. For your convenience we encourage you to make one payment at the beginning of the week of your scheduled appointments.

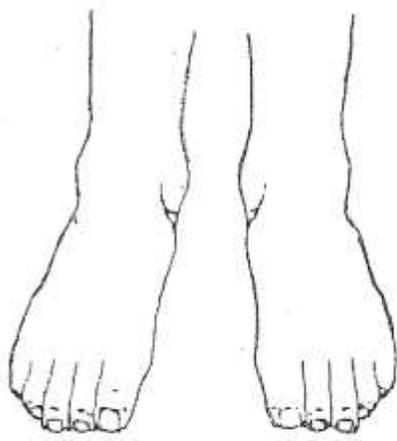
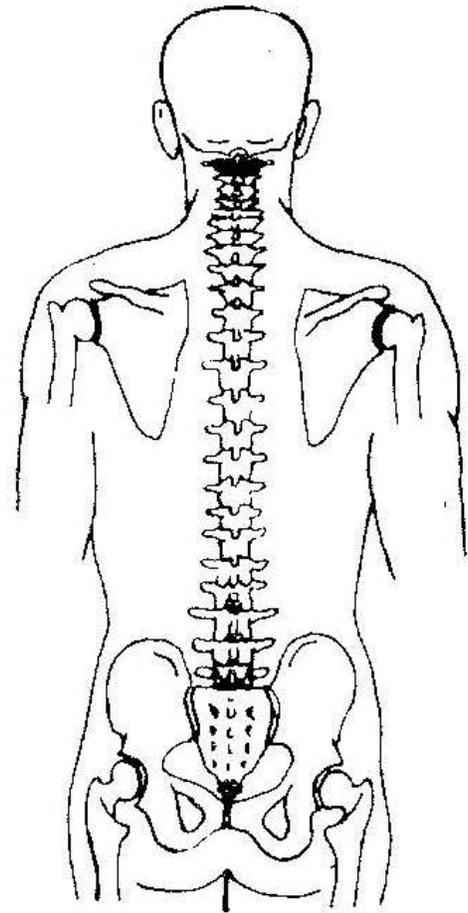
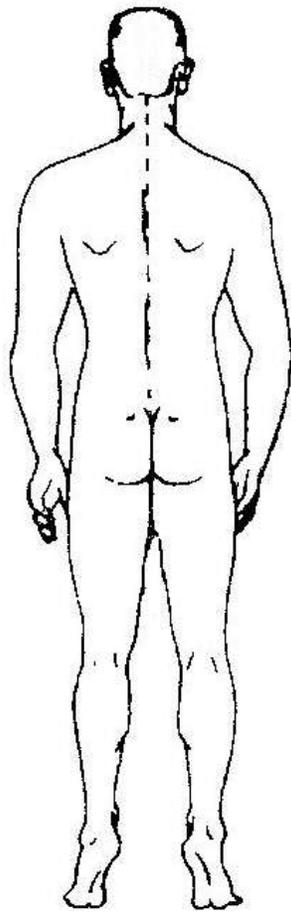
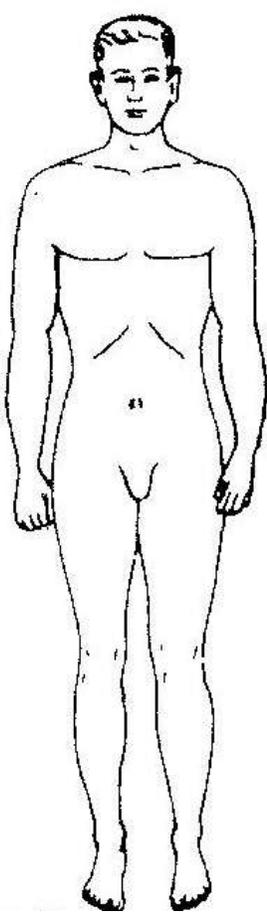
You are responsible for attending the specific appointments within a certain time frame. We require 24 hours notice for rescheduling or cancelling your appointment. Failure to do so will result in a missed appointment fee of \$25.00. There is a \$10.00 charge for each NSF cheque.

If a new condition arises, or if there is a change in your personal information, ie. address, workplace, marital status etc., please advise the clinic staff as soon as possible, so that we can update your file.

I have read and understand the policies of this clinic, as noted above. I understand that I am personally responsible for payment of all services rendered to me and that if I am discharged or discontinue treatment, that any balance on my account is immediately due and payable.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please shade in your areas of pain on the figures below



Right

Left

