Truro Chiropractic Clinic Inc.

File#_____ Date ____/____/____

Last name_____
First Name_____
Salutation Mr___Mrs___ Ms___Dr___
Date of birth D_____M_____Y_____

Marital status_____
Spouse's name_____
Child's name&age___
_____
_____
_____

Home address_____
City/town _____
Province _____
Postal code _____
Home phone (___)_____
Cell phone (___)_____
Which # should we try first?_____

Employer_____
Occupation_____
Work address_____
Work phone(___)_____

Emergency Contact:
Name_____
Relationship_____
Phone(___) _____
Medical Doctor_____
Health card#_____

How did you choose us for
your health care?
Friend(name)_____
Physician(name)_____
Yellow Pages_____ Sign_____
Other_____

Complete this area if visit is due to a WCB____ or MVA____ case:

Company name_____
Contact name_____
Phone #_____

Policy/Claim#_____
SIN#_____

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*

MUSCULO-SKELETAL

__ Low back problems
__ Pain between shoulders
__ Neck problems
__ Arm pain
__ Swollen joints
__ Leg pain
__ Stiff joints
__ Muscle cramps
__ Muscle weakness
__ Walking problems
__ Ruptures (hernias)
__ Broken bones or fractures
__ Dislocations
__ Bone disease
__ Other_____

NERVOUS SYSTEM

__ Incoordination
__ Tremors
__ Loss of feeling
__ Paralysis
__ Dizziness
__ Fainting
__ Frequent headaches
__ Muscle twitching
__ Convulsions/seizures
__ Forgetfulness
__ Confusion
__ Depression
__ Other_____

FEMALES ONLY

__ Menopause
__ Discharge from nipples
__ Lumps in breast
__ Breast pain
__ Vaginal discharge
__ Abnormal menstruation
__ Painful menses
__ Contraceptives
__ # of pregnancies
__ # of children
__ Other_____
_____

GASTRO-INTESTINAL

__ Poor appetite
__ Excessive appetite
__ Difficulty swallowing
__ Excessive thirst
__ Heartburn
__ Excessive gas
__ Excessive bleeding
__ Frequent nausea
__ Frequent vomiting
__ Vomiting blood
__ Ulcers
__ Irregular bowel movement
__ Intestinal infection
__ Indigestion
__ Red or tar coloured stools
__ Hemorrhoids
__ Frequent diarrhea
__ Frequent constipation
__ Weight trouble
__ Diabetes
__ Other_____

CARDIOVASCULAR

__ Chest pain
__ Racing heartbeat
__ Swelling of feet or ankle
__ Varicose veins
__ Fainting spells
__ Blood pressure problems
__ Cramps in legs
__ Poor circulation
__ Jaundice
__ Anemia
__ Stroke
__ Other_____

RESPIRATORY

__ Constant cough
__ Excessive phlem(sputum)
__ Coughing up blood
__ Wheezing
__ Asthma
__ Bronchitis
__ Other_____

GENITO-URINARY

__ Irregular urination
__ Painful urination
__ Bladder infection
__ Excessive urination
__ Scanty urination
__ Discoloured urine
__ Weak bladder
__ Kidney stones
__ Prostate trouble
__ Other_____

EYES

__ Pain
__ Blurring
__ Bothered by light
__ Infection
__ Loss of vision
__ Cataracts
__ Other_____

EARS

__ Pain
__ Hearing loss
__ Ringing in ears
__ Discharge from ears
__ Infection
__ Other _____

Nose

__ Discharge
__ Sinus problems
__ Other_____

Throat

__ Hoarseness
__ Frequent sore throats
__ Enlarged thyroid
__ Enlarged glands

MOUTH

__ Bite plane for TMJ
__ Gum disease
__ Swollen gums
__ Painful gums
__ Change in taste
__ Bleeding gums
__ Other

SKIN	DISEASES	Medication
__ Rashes __ Lumps __ Bruise easily __ Other_____	__ Cancer __ Measles __ Mumps __ Chicken Pox __ German measles __ Whooping cough __ Scarlet fever __ Rheumatic fever __ Diptheria __ Hip joint disease __ Small pox __ Pneumonia __ Tuberculosis __ Malaria __ Polio __ Typhoid fever __ Other_____	__ Insulin __ Antacid __ Heartburn remedy __ Laxative __ Water pill __ Aspirin __ Muscle relaxant __ Tranquilizer __ Blood pressure pill __ Birth control pill __ Mega dose vitamin __ Pain killer __ Nerve pill __ Pep pill __ Narcotic __ Anti-inflammatory __ Other
ALLERGIES		
__ Food _____ _____ __ Feathers __ Flowers or Pollen __ Animals __ Dust __ Perfume and scents _____ __ Other _____ _____ _____ _____		

Habit	Frequency
Coffee	___ cups per day
Tea	___ cups per day
Cigarettes	___ packs per week
Alcohol	___ drinks per week
Sleep	___ hours per night

Do you wear orthotics?Y__ N__

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