Barrie Chiropractic & Health Services Centre
55 Cedar Pointe Dr. Unit 604 Barrie, ON L4N 5R7 705-792-6690
Cookstown Chiropractic
29 Queen Street Cookstown, ON L0L 1L0 705-458-8288
Dr. Darryl Bossence • Dr. Mark Trudeau

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:
Please complete this questionnaire. Your answers will help us to determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name: _____ Birth Date: _____Age: _____

Mailing Address:_____City: _____

Postal Code:_____ Home Phone: _____ Business Phone:_____

Marital Status: M S W D Spouse's Name: _____ Do you have Children? _____

Employer: _____ Occupation: _____

Name of person who referred you to our office: _____

HEALTH INFORMATION

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What makes it feel better? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? _____ Have you had x-rays of your spine in the past year?_____

Have you had other doctors treat this condition / who? _____

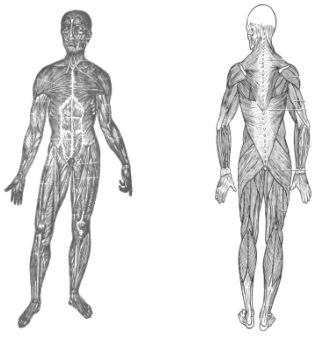
Height: ____feet ____ inches Weight: _____ lbs. Shoe Size: _____ Shoe Width: _____ (narrow, regular, wide)
Activity Level: (circle one) Low Medium High

Have you ever suffered from: (circle Yes or No)

Dizziness	Yes	No	Heart Trouble	Yes	No
Backaches	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Headaches	Yes	No
Asthma	Yes	No	Neck Pain	Yes	No
Neuritis	Yes	No	Digestive Disorders	Yes	No
Sinus Trouble	Yes	No	Nervousness	Yes	No

Other:_____

Please circle areas of pain



CONFIDENTIAL PATIENT CASE HISTORY

Name: _____

Other complaints? _____

Have you had previous chiropractic care?_____ When?_____

Name of Chiropractor: _____Where? _____

Why? _____

Family Doctor's Name: _____ Last Physical Exam: _____

List surgical operations and dates: _____

.....

Do you now take: Please check off all that apply

Tranquilizers _____ Birth Control Pills_____
Muscle Relaxers_____ Vitamins_____
Pain Killers _____ Pep Pills _____
Insulin _____ Nerve Pills_____

How do you sleep?

On your stomach____ On your side____ On your back____
Age of your mattress: _____
Are you comfortable at night? _____
How many hours of sleep do you get?_____

Are you wearing: Yes or No
Heel lifts_____ Sole lifts_____ Arch Supports _____

Have you ever been in an automobile accident? _____

If yes, please indicate if it occurred within: the past year _____ past 5 years _____ over 5 years _____

What were your injuries? _____

What are your interests & hobbies? _____

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weaknesses. The information requested about your immediate family members will give us a better picture of your health.

Have you or a family member had a history of the following: (please check off the applicable answers)

Asthma_____	Cardiovascular Disease_____	Lumbago_____	M.S._____
Allergies_____	Learning Disability_____	Diabetes_____	H.I.V._____
Arthritis_____	Hyperactivity_____	Epilepsy_____	Cancer_____
Alcoholism_____	Stomach Ulcers_____	Bed Wetting_____	Depression_____
Schizophrenia_____	Other:_____		

I understand and agree that health and accident policies are an arrangement between my insurance carrier and myself. I clearly understand and agree 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. I consent to the examination by the Doctor.

_____ _____ _____

Print Name Signature Date