Back to Health

CHIROPRACTIC

Clinic

Welcome to our office

To ensure your visit with us is a pleasant one, here are the procedures you can expect during the next 60 minutes.

PAPERWORK: Complete this brief questionnaire and your health history form to help us to get to know you. Your chiropractor will use this information to help formulate the recommendations for your care.

EXAMINATION: A computerized scan of your spine will be performed and a detailed history will be taken. You will meet the doctor and standard physical, orthopaedic, neurological and chiropractic tests will be performed to determine if yours is a chiropractic case.

SPINAL IMAGES: If necessary your chiropractor may send you for spinal images to visualize the location of any spinal problems, neurological interferences, and reveal any pathologies.

DOCTORS REPORT/FIRST ADJUSTMENT: On your next visit, your chiropractor will review your findings with you and your spouse/partner. If appropriate you will receive your first chiropractic adjustment at this time. Your chiropractor will then review the best care plan for your recovery.

CONFIDENTIAL PATIENT HISTORY

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Name: _____ Email: _____

Birth date: / / / / /(/DD/ /MM/ /YEAR/) Health number: _____

Spouse/Partners Name: _____ Health insurance: Yes ☐ No ☐

Address: _____ Which company? _____

City: _____ Occupation or Profession: _____

Province: _____ Postal Code: _____ Employed by: _____

Home Phone: _____ Do you primarily sit or stand at work: _____

Cell phone: _____ Work Related Injury (WCB) Yes ☐ No ☐

Work phone: _____ Recent Motor Vehicle Accident? Yes ☐ No ☐

How did you choose our office? _____ Claim number for either MVA or WCB: _____

Who may we thank for your referral? _____ Date of injury: / / / / /(/DD/ /MM/ /YEAR/)

What is the main goal that you would like to reach through chiropractic? _____

_____

RECORDS RELEASE AND SCHEDULING: Back to Health Chiropractic Inc, may disclose information from my records to doctors, hospitals or others for continuity of care and to any third party who requires information in order to fulfill an obligation benefiting me. I understand that payment for services is due in full at the time the service is rendered and that I may use cash, Visa, MasterCard or Debit. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, any amount authorized to be paid directly to this clinic by a third party will be credited directly to my account upon receipt. However, I understand that if I discontinue my care, any fees for services rendered to me will be immediately due and payable. All appointments during regular hours must be scheduled in advance. **Appointment cancellation requires 24 hours notice or there may be a $25.00 cancellation fee.**

Signature: _____ Date signed: _____

Thank you for choosing our office, we look forward to a healthy relationship with you!

271 Sackville Dr. • Lr. Sackville • NS • B4C 2R5 • T(902)865-8500 • F(902)865-8502 • www.backtohealthchiropractic.ca

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Patient's Name:	Date:	File #:

HEALTH FACTORS

	Heavy	Moderate	Light	None	(other details)
Physical Activity	☐	☐	☐	☐	
Water Intake	☐	☐	☐	☐	
Stress	☐	☐	☐	☐	
Coffee, Tea	☐	☐	☐	☐	
Cola, Energy Drinks	☐	☐	☐	☐	
Alcohol	☐	☐	☐	☐	
Smoking	☐	☐	☐	☐	

	Excellent	Good	Fair	Poor	(other details)
Diet	☐	☐	☐	☐	
Sleep pattern	☐	☐	☐	☐	

LIST YOUR HEALTH PROBLEM(S) IN ORDER OF SEVERITY ALONG WITH THE DATE EACH STARTED:

Problems:	Date:	Problems:	Date:
1)		3)	
2)		4)	

Do you have a family physician? Yes or No Name:

Do you have an illness?

Please list all medication you are currently prescribed:

List all over-the-counter medications, vitamins and supplements:

List all injuries, accidents, fractures and date:

List all surgeries, hospitalisations and date:

FAMILY HISTORY (Please rate the overall health of your family members)

	Excellent	Good	Fair	Poor	Deceased	(give cause)
You	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	
Mother	☐	☐	☐	☐	☐	
Sibling 1	☐	☐	☐	☐	☐	
Sibling 2	☐	☐	☐	☐	☐	
Sibling 3	☐	☐	☐	☐	☐	

Do any conditions run in your family?

CHECK IF THERE IS A FAMILY HISTORY OF:

Heart trouble	☐	Diabetes	☐	Cancer	☐	High Cholesterol	☐
Hypertension	☐	Stroke	☐	Arthritis	☐	Neurological illness	☐

CIRCLE ANY CONDITIONS YOU HAVE OR EVER HAD:

Alcholism	Cancer	Eczema	Goiter	Measles	Rheumatic F.	Stroke	Other:
Allergies	Chicken Pox	Emphysema	Gout	M.Sclerosis	Rhumatoid A.	Trauma	_____
Anemia	Convulsions	Epilepsy	Hepatitis	Mumps	Rubella	Tuberculosis	_____
Appendicitis	Depression	Fibromyalgia	HIV	Obesity	Scarlet Fever	Ulcers	_____
Arthritis	Diabetes	Food Intoler.	Leukemia	Polio	Shingles	Weakness	_____
Asthma	Drug abuse	Glaucoma	Marfan	Psoriasis	Stress	Weight Loss	_____

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Patient's Name:	Date:	File #:

HEALTH HISTORY: *Do any of the following apply to you?*

SKIN AND NAILS
- ☐ rashes
- ☐ skin lumps
- ☐ dry skin
- ☐ itchy skin
- ☐ easily bruise
- ☐ brittle nails
- ☐ eczema
- ☐ hives

HEAD
- ☐ head injury
- ☐ headaches
- ☐ migraines
- ☐ dizziness
- ☐ double vision
- ☐ memory lapse
- ☐ blurred vision
- ☐ see spots

EARS
- ☐ ear pain
- ☐ hearing loss
- ☐ ear infections
- ☐ ringing in ears
- ☐ loss of balance
- ☐ vertigo
- ☐ meniere's
- ☐ BPPV

MOUTH & THROAT
- ☐ clicking jaw
- ☐ teeth grinding
- ☐ braces/dentures
- ☐ throat pain
- ☐ bleeding gums
- ☐ swollen glands
- ☐ difficulty swallowing
- ☐ gagging or choking

RESPIRATORY
- ☐ frequent colds
- ☐ chest pain
- ☐ chest noises
- ☐ shortness of breath
- ☐ chronic cough
- ☐ coughing phlegm
- ☐ coughing blood

NOSE & SINUSES
- ☐ snoring
- ☐ nosebleeds
- ☐ broken nose
- ☐ sinus pain
- ☐ sinus infections
- ☐ sinus congestion
- ☐ loss of smell

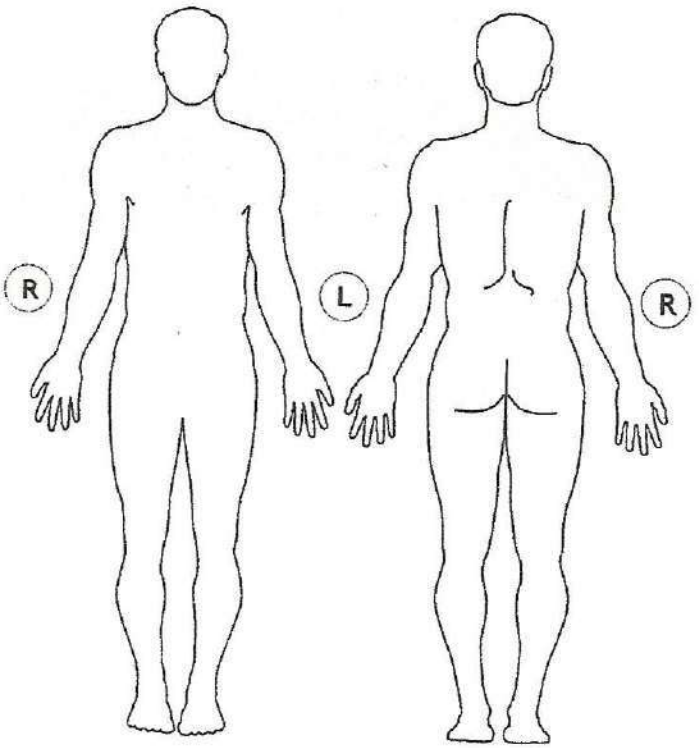
DIGESTIVE
- ☐ celiac disease
- ☐ abdominal pain
- ☐ nausea/vomiting
- ☐ acid reflux
- ☐ constipation
- ☐ diarrhea
- ☐ irritable bowel

NERVOUS SYSTEM
- ☐ numbness
- ☐ pins and needles
- ☐ tingling or twitching
- ☐ aching or throbbing
- ☐ shooting/shock-like pain
- ☐ coordination problems
- ☐ seizures/ convulsions

GENITAL & URINARY
- ☐ difficult urination
- ☐ frequent urination
- ☐ abnormal urine colour
- ☐ night-time urination
- ☐ painful urination
- ☐ veneral disease
- ☐ loss of urinary control
- ☐ loss of bowel control
- ☐ loss of sensation

CARDIOVASCULAR
- ☐ pacemaker
- ☐ irregular heart beat
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ fainting spells
- ☐ previous heart attack
- ☐ swollen ankle(s)/feet
- ☐ heart murmur
- ☐ bleeding disorder

On the diagram below circle pain and/or numbness:



MUSCULOSKELETAL
- ☐ scoliosis
- ☐ osteoporosis
- ☐ osteoarthritis
- ☐ muscle weakness
- ☐ muscle cramps
- ☐ joint swelling or noises

FEMALE ONLY

Are you currently pregnant: Yes/No
Number of childrens:
Difficult pregnancies: Yes/No
Age of first period:
Menstrual cramps: Yes/No
Breast lumps or bioposies: Yes/No
Age of menopause:
Hot flashes: Yes/No
Date of last gynocological examination:

MAN ONLY

Date of last prostate examination:

Do you have any conditions which have not been listed? Please list:

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Subscriber Enrollment

As an extension of the care you receive in our practice, may we add you as a subscriber to our website that will help you...

Get Well and Stay Well.

First name : _____ Last name : _____

Date of birth : _____ / _____ / _____

Email address : _____

Naturally you can unsubscribe at any time.