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www.FrederictonFamilyChiropractic.ca



Personal Information

Today's Date (mm/dd/yy): _____ / _____ / _____

Name (first/last): _____

Age: _____ Gender: M F Date of Birth (mm/dd/yy): _____ / _____ / _____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone (Home): _____ (Other): _____

May we leave phone messages, if need be? Yes No

Email: _____

May we communicate with you via email? Yes No

Name of Spouse/Partner: _____

Is your spouse/partner a patient here? Yes No

What is your occupation? _____

Do you primarily: Sit Stand Perform Repetitive Tasks

Names/Ages of Children: _____

How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? Yes No

If yes, where? _____ When? _____

Reason for last visit: _____

Do you feel your previous chiropractic care was effective? Yes No

Please explain: _____

Do you currently see a registered massage therapist? Yes No

Do you currently see a naturopathic doctor? Yes No

If yes to either, please explain: _____

Family Medical Doctor: _____ Phone: _____

Date and reason for last visit: _____

May we contact your family doctor regarding your care in this office, if necessary? Yes No

Have you had an x-ray, MRI, or CT scan done in the last 6-12 months? Yes No

If yes, for what reason? _____

Current Health Profile

What brings you into our office?

- I have a specific complaint, symptom, or health concern.
- I want to have my spine & nervous system assessed to see if they are functioning as they should.
- Other _____

Symptom Profile

What is your primary complaint(s)? _____

When did this problem begin? _____

Have you had this type of problem before? Yes No

Do you believe this problem is from:

one particular event or

an accumulation of numerous injuries/stresses over many years?

Please explain: _____

Please circle the intensity of this problem today: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

How would you describe the pain/discomfort? _____

Is your problem getting progressively worse or improving? _____

Have you seen any other health care provider for this problem? Yes No

If yes, please explain: _____

What have you tried that has helped? Ice Heat Medication Massage therapy Chiropractic

Other (please specify) _____

What has not helped? Ice Heat Medication Massage therapy Chiropractic

Other (please specify) _____

Is your current problem/symptom the result of a motor vehicle accident and/or work related injury?

Yes No If yes, please explain: _____

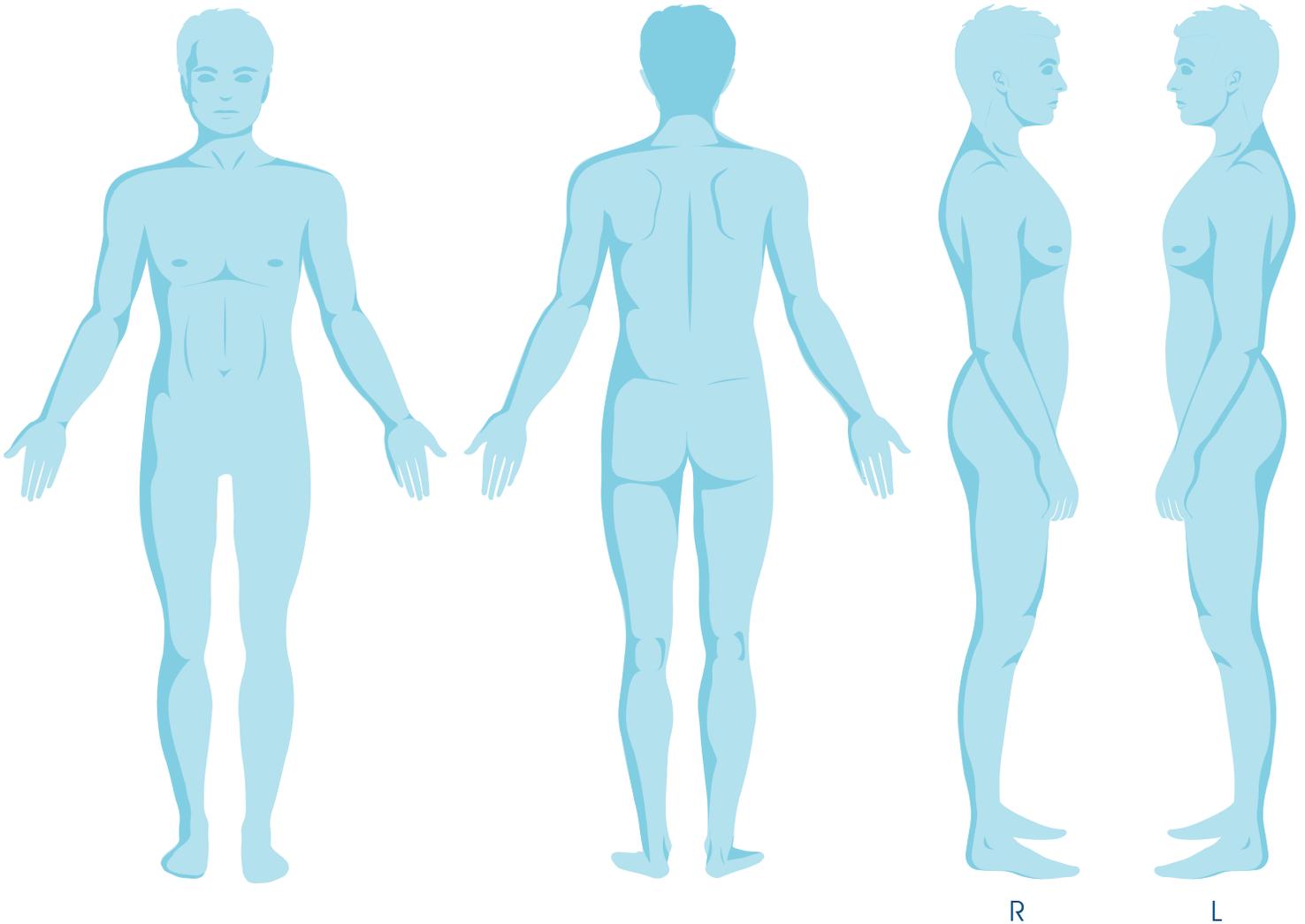
How is this problem affecting your quality of life? (depression, not enjoying normal activities, reducing ability to

exercise, too many medications, etc) _____

Symptom Profile cont'

Please fill in the diagram with the appropriate symbols from the legend, if applicable:

LEGEND: A = ache N = numbness P = pins & needles T = stiffness
 B = burning R = radiating S = stabbing O = other



Notes: _____

Final Thoughts

What are the top 3 outcomes you hope to achieve by consulting our office?

- 1) _____
- 2) _____
- 3) _____

Do you have other concerns about your health that we have not addressed but you would like us to know about? Yes No

If yes, please explain:
