

Practice Member Information

Last Name		First Name		Middle	Birth date MM DD YYYY		
Health Card Number		Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> NB		Email Address		
How did you hear about us? <input type="checkbox"/> Care Provider <input type="checkbox"/> Google		<input type="checkbox"/> Family/Friend/Colleague (Provide Name) _____			Cell Number		
Home Number	Name of Spouse		Name of Children				
Employer		Occupation			Work Number		

Practice Member's Address

Street		Unit/Apt #	City	Province	Postal Code
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Family Doctor No Yes

Name of Doctor		Phone Number		Date of last visit MM DD YY		Date of last exam MM DD YY	
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Family Doctor's Address

Street		City	Province	Postal Code
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Previous Chiropractor No Yes

Name of Chiropractor		Describe your experience			Date of last visit MM DD YY	
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Current Illness/Conditions

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dislocated joints | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental/emotional difficulty | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Swollen feet/legs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Bone fracture | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Tired/achy legs |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cirrhosis/hepatitis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Degenerative disc/
joint disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Venous insufficiency |

Describe conditions and any others not listed:

Family History of Illness

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental/emotional	List relationship, illness, age of diagnosis, details
<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Postural/feet	
<input type="checkbox"/> Cancer	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Stroke/TIA	

Lifestyle

Your current weight

lbs kg

Your height

in cm

Your ideal weight

lbs kg

Alcohol

No Yes

Drinks per week: _____

Cigarettes

No Yes

Amount per day: _____

Marijuana

No Yes

Describe use: _____

Exercise

No Yes Hours per week: _____

Light Moderate Strenuous

Which of these 4 best describes your nutrition style?

1. I eat homecooked meals mostly. Check all that apply.

- Cultural/traditional: _____ Omnivorous/Everything Paleo/Keto Vegetarian Mediterranean
 Limiting carbs/calories Plant-rich including oil Whole food plant-based vegan (limited oil, sugar, salt)

2. I try to get some fruits, vegetables and salad daily, otherwise mostly packaged or fast food.

3. I eat anything and everything, mostly packaged or fast foods.

4. I am currently shifting my diet to something healthier. Describe.

Do you have a daily spiritual or mindset practice?

- No Yes, check all that apply
- | | | | | | |
|---|-------------------------------------|--------------------------------------|---------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Prayer | <input type="checkbox"/> Meditation | <input type="checkbox"/> Gratitude | <input type="checkbox"/> Journaling | <input type="checkbox"/> Accountability | |
| <input type="checkbox"/> Online group/program | <input type="checkbox"/> Nature | <input type="checkbox"/> Yoga | <input type="checkbox"/> Goal-setting | <input type="checkbox"/> Affirmation | <input type="checkbox"/> Coaching |
| <input type="checkbox"/> Visualization | <input type="checkbox"/> Reading | <input type="checkbox"/> Other _____ | | | |

Describe your lifestyle concerns and activity level:

Reasons for joining our practice

What are your major health goals and conditions you wish to improve?

- | | | |
|--|---|---|
| <input type="checkbox"/> Custom Orthotics | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Extremity | <input type="checkbox"/> MVA/WSIB | <input type="checkbox"/> Spinal Maintenance |
| <input type="checkbox"/> Flexibility | <input type="checkbox"/> Nerve Symptoms | <input type="checkbox"/> Sports Performance |
| <input type="checkbox"/> Headache/Migraine | <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Injury Rehab | <input type="checkbox"/> Posture | <input type="checkbox"/> Wellness |

Describe your health goals

Further Systems Review

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Arteries hardening | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hernia | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Bladder issues | <input type="checkbox"/> Dry skin/rashes | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Swelling/lymph |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Ear aches/noises | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Chest pain/rapid beats | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Loss of control of urine | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Colitis/irritable bowel | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neuralgia/numbness/tingling | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Gas/bloating | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Yeast infections |

List any symptoms, health concerns or diagnoses not described elsewhere:

Surgeries list and approximate dates

Diagnostic Imaging and approximate dates (X-Ray, Ultrasound, CT, MRI)

Musculo-Skeletal-Neurological Symptoms

	Left	Right		Left	Right		
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/> Pain/ache/burn
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Frozen shoulder	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Upper back/ blades	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Golfer's/tennis elbow	<input type="checkbox"/> Skin hypersensitive
<input type="checkbox"/> Upper arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thigh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Jaw pain/TMJ	<input type="checkbox"/> Spasms
<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Inner Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neurologist visit	<input type="checkbox"/> Swelling
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Outer Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Numb/tingling arms	<input type="checkbox"/> Tendonitis
<input type="checkbox"/> Wrist/hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lower leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Numb/tingling legs	<input type="checkbox"/> Shoulder tension
<input type="checkbox"/> Rib/side chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ankle/foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other specialist	<input type="checkbox"/> Visual disturbance

Describe previous diagnoses, specialists, locations and symptoms further (if applicable):

Sleep Posture and Habits

Side sleeper Back sleeper Front sleeper Orthopedic pillow Well rested Fatigued

Describe sleep issues, pillow type/brand and mattress concerns (if applicable):

Ergonomics, Work and Play Tell us what might be aggravating your current condition.

Hours @ computer/ games per day	Hours sitting	Hours standing	Rate stress <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low
<input type="checkbox"/> Heavy lifting <input type="checkbox"/> Twisting/bending <input type="checkbox"/> Phone cradled neck	"Self time" <input type="checkbox"/> No <input type="checkbox"/> Yes	Other factors	

Describe stress, list hobbies, work/home issues and ergonomic challenges:

Supplements

High Quality Multivitamin <input type="checkbox"/> No <input type="checkbox"/> Yes	Mag/Vit D3 <input type="checkbox"/> No <input type="checkbox"/> Yes	Hormonal supplement <input type="checkbox"/> No <input type="checkbox"/> Yes	Glucosamine for joints <input type="checkbox"/> No <input type="checkbox"/> Yes
High Quality Omega 3 <input type="checkbox"/> No <input type="checkbox"/> Yes	Vitamin B12 <input type="checkbox"/> No <input type="checkbox"/> Yes	Other (list) <input type="checkbox"/> No <input type="checkbox"/> Yes _____	

Falls, Accidents, Hospital Visits, Medications

Fall MVA Work Injury Emergency visit Hospitalization Unconsciousness Medications

Is this a workplace injury or motor vehicle collision claim? No Yes

List any conditions, recreational drug use, prescribed and/or OTC medications (length of use and dosages).

Women Only

Is there any chance that you might be pregnant?
 No Yes

Cramps Irregular Cycle Discharge
 PMS Painful Cycle Pre/Menopausal

Describe symptoms, delivery due date and/or menopause experience/dates

Self-assessment		
	Location 1	Location 2
Where are your symptoms?		
On a scale of 1-10, how intense is it now? (10 = worst)		
When did it start? Approximate date?		
How did it start? After or during which activities or events. Please describe.		
Have you had it before? If so, when?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
For this episode, how often does it bother you/notice it? CHECK ONLY ONE	<input type="checkbox"/> Constantly <input type="checkbox"/> 2-3/week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Daily <input type="checkbox"/> 1/week <input type="checkbox"/> Most days <input type="checkbox"/> 1/month	<input type="checkbox"/> Constantly <input type="checkbox"/> 2-3/week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Daily <input type="checkbox"/> 1/week <input type="checkbox"/> Most days <input type="checkbox"/> 1/month
What does it feel like? CHECK ALL THAT APPLY	<input type="checkbox"/> Shooting <input type="checkbox"/> Spasm <input type="checkbox"/> Numb <input type="checkbox"/> Sharp <input type="checkbox"/> Tension <input type="checkbox"/> Tingling <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Dull ache <input type="checkbox"/> Other: _____	<input type="checkbox"/> Shooting <input type="checkbox"/> Spasm <input type="checkbox"/> Numb <input type="checkbox"/> Sharp <input type="checkbox"/> Tension <input type="checkbox"/> Tingling <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Dull ache <input type="checkbox"/> Other: _____
Does it travel from one place to another in your body?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe where:	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe where:
What positions or activities make it feel worse? Sleep, work, etc.		
What positions or activities make it feel better? Stretch, walk, rest, stand, sit, etc.		
Have treatment, home care or other interventions helped? Please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Please help your CCHC team help you, let us know how by checking all that apply		
<input type="checkbox"/> Home exercise programs <input type="checkbox"/> Massage therapy <input type="checkbox"/> Custom orthotics <input type="checkbox"/> Mindset workshops	<input type="checkbox"/> Compression stockings <input type="checkbox"/> Online community <input type="checkbox"/> Nutrition workshops <input type="checkbox"/> Ergonomic tools/recommendations	<input type="checkbox"/> Supplement assessment and recommendations <input type="checkbox"/> Support you in referring family, friends and/or co-workers
Do you have insurance that you want us to attempt direct billing to on your behalf? <input type="checkbox"/> No <input type="checkbox"/> Yes		
On a scale of 1-10, how happy are you so far with your CCHC experience? (10 = best)		
I have stated all conditions that I am aware of accurately and will inform CCHC of any changes to my contact information and status. All information on this form is strictly confidential and will become part of your chiropractic record. For more information, please refer to our Privacy Policy or contact us for more details.		
Would you like to receive communications by email?		
<input type="checkbox"/> I accept appointment e-reminders, e-statements and other e-communication. <input type="checkbox"/> I do not want to communicate by email or receive e-reminders, e-statements, e-communication		
Signature	Date	
	MM	DD YYYY
To avoid paying late cancellation and missed appointment fees, please provide the required notice: Initial Assessments: 48 hours required Subsequent Visits: 24 hours required		