*We are pleased to welcome you to our practice. Please take a few minutes to fill this form out **completely**.*
We look forward to working with you in enhancing & maintaining your health.

Name:_____ **Age** _____ **Health Card #**_____

Address:_____ **City:** _____ **Prov.** ___ **Postal Code** _____

Phone: **HOME** (___)_____ **CELL** (___)_____ **WORK** (___)_____

Email: _____ **May we e-mail you? __ Y __ N** *(appointment reminders & newsletters)*

Birth Date: _____ **Sex**: **M / F** **Marital Status**: **S M D W** **Occupation:** _____

Emergency Contact Name: _____ **Emergency Contact Phone**: (___)_____

Medical Doctor: _____ **Last Seen?** _____ **Purpose**: _____

Who may we thank for referring you? _____

Why This Form is Important

*As a full spectrum Chiropractic office, our goals are, **first**, to address the issues that brought you to this office, and **second**, to offer you the opportunity of improved health potential and wellness services in the future.*

Have you ever been to a Chiropractor for treatment? __Y __N
If Yes, when & why? _____

Reason for this visit: __ **specific concern** __ wellness/spinal check- up **__** no complaints
Are you here for: __ Correction of the cause(s) OR __ Temporary/patch (relief) care

Specific Concern, describe:_____

Date the symptom(s) began: _____ Have you had similar condition(s)? __Y __N

How did it **start**? _____

What makes it **worse**? _____

What makes it **better**? _____

Describe your symptom: __Sharp __Dull __Throbbing __ Burning __Aching __Stabbing __ Other

Does it **radiate** (travel)? __ Y __ N If so, where? : _____

Is the Condition/Problem getting: **__ Worse** **__ Better** **__ Same** **__ Comes & goes**

Frequency? __ Constant __ Occasional

Pain Intensity? *(none)* **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10** *(worst)*

Does this problem **interfere** with: __ work __ sleep __ personal life __mood __ activities

Who have you seen for this? _____ **What** did they do?_____

Have you had **X-rays**, **MRI**, or **other tests** for this? __ **Y** __ **N** Which tests & When? _____

Does this effect daily **home/work** activities? __ **Y** __ **N** Explain: _____

Is this injury: ___ **Work** Related ___ **Auto** Accident ___ **Personal** Injury ___ Other

Please note that this office does NOT accept WCB cases.

Has the injury/accident been **reported**? __**Y** __**N** If so, to whom? __ Employer __ Auto Carrier __ MD

Admitted to the **hospital**: __**Y** __**N** Hospital:_____ Length of Stay _____

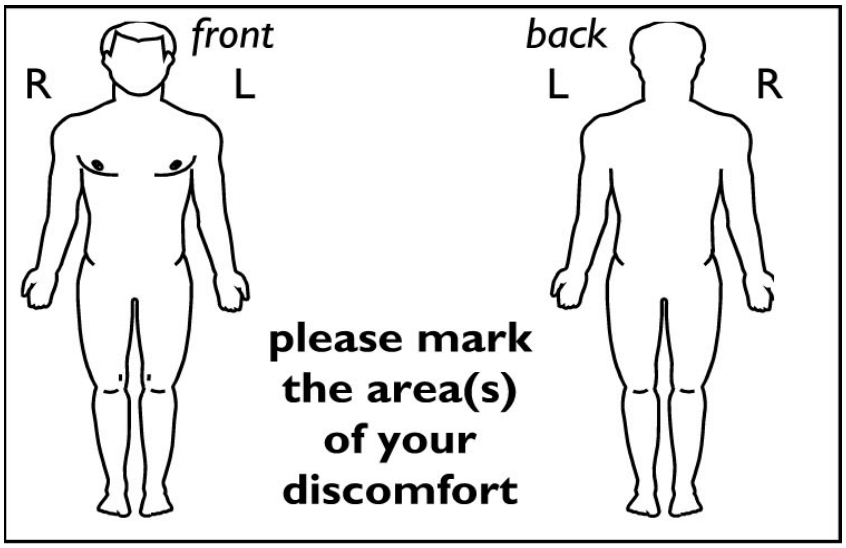
Transported by: __ EMS __ Police __Other Date Admitted: _____ Date Released: _____

Current **work restrictions** related to this? __**Y** __**N** **Off work**? __ **Y** __ **N** From _____ To _____

Light Duty? __Y __N List **Restrictions**:_____

Past **auto accident**(s)? __**Y** __**N** When? _____ Describe: _____

Please mark the illustration below where you are experiencing issues



Stress level: __ None ___ Mild ___ Moderate ___ High

Sleep: __ Good __Poor **How Long**? ___ hours **Position**? __Back __Stomach __ Side

SUPPLEMENTS (list): _____

MEDICATIONS (list): _____

ALLERGIES (including meds): _____

Previous **surgeries, illnesses, injuries**: _____

_____

WOMEN Only: **Pregnant**? __Y __N If **No**: Last Menstrual Date: _____ If **Yes**: Due Date: _____

__ Painful cycles __Irregular Cycles __ PMS/Menstrual Cramps __ Hot Flashes __ Menopause

HABITS

__ Smoking (packs/day) ___
__ Alcohol (cups/day) ___
__ Coffee (cups/day) ___
__ Soft drinks (cans/day) ___
__ Rec. Drugs ___
__ Water (cups/day) ___

EXERCISE

__ None
__ Moderate
__ Heavy

FAMILY HISTORY

	Diabetes	Cancer	Heart	Back Pain	Other
Mother	___	___	___	___	___
Father	___	___	___	___	___
Siblings	___	___	___	___	___
Children	___	___	___	___	___

Check all that apply to you:

General Symptoms
__ Allergy
__ Fatigue
__ Headache
__ Convulsions
__ Dizziness
__ Hemorrhoids
__ Thyroid Prob.
__ Loss of Sleep
__ Nausea
__ Loss of Weight
__ Nervousness
__ Night Sweats
__ Stress/tension
__ Anxiety
__ Depression
__ Mood Swings/Irritability
__ High Blood Pressure
__ Heart Problems/Stroke

Gastro-intestinal
__ Belching or Gas
__ Constipation
__ Diarrhea
__ Bloody Stools
__ Gall Bladder
__ Frequent urination
__ Blood in Urine
__ Painful Urination
__ Stomach Pain
__ Kidney Infection
__ Kidney Stones
__ Heart Burn
__ Ulcers
__ Vomiting
__ Vomiting Blood

Eye/Ear/Nose/Throat
__ Asthma
__ Deafness
__ Earache
__ Ear Discharge
__ Ear Noises
__ Nasal obstruction
__ Sinusitis
__ Nose Bleeds
__ Pain in Eyes
__ Poor Vision
__ Blurred Vision
__ Ringing in Ears
__ Loss of Smell

Respiratory
__ Chest Pain
__ Chronic Cough
__ Spitting Blood
__ Spitting Phlegm
__ Fainting
__Wheezing
__ Bronchitis
__ Short of Breath

Muscle & Joint
__ Neck pain/stiffness
__ Low Back pain
__ Mid Back pain
__ Swollen joints
__ Foot or Knee pain
__ Shoulder pain
__ Hip pain
__ Faulty posture
__ Spinal Curvature
__ Arthritis
__ Numbness _____
__ TMJ/Jaw pain
__ Cold Hands/Feet
__ Balance prob.
__ Co-ordination

Do you **have OR have you had** any of the following?

__ Appendicitis
__ Measles
__ Influenza
__ Lumbago
__ Cancer
__ Anemia
__ Goiter
__ Polio
__ Diabetes
__ VD
__ Heart Disease
__ Rheumatic fever
__ Mental Disorder
__ Tuberculosis
__ Whooping Cough
__ Arthritis
__ Epilepsy
__ Pleurisy
__ Eczema
__ HIV Positive
__ Pneumonia
__ Mumps
__ Chicken Pox
__ Alcoholism
__ Stroke/TIA

Patient / Guardian **Signature**: _____ Date: _____