

# Patient Information

Thank you for choosing our practice for your chiropractic care. If you have any questions, do not hesitate to ask for assistance. We will be happy to help!

(Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_  Male  Female  
First Last

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_  
YYYY MM DD

Do you prefer to receive calls at:  Either  Home  Work  Cell

Email Address: \_\_\_\_\_ Cell# \_\_\_\_\_

Would you like to receive our free health newsletters by email  Yes  No

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Is your condition the result of a motor vehicle injury or work-related injury? If yes, Date of accident \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_ Date of last check-up or physical? \_\_\_\_\_

Have you previously received chiropractic care?  Yes  No  
Name of Chiropractor Date of last visit

Do you have extended health coverage? Company Name: \_\_\_\_\_

How did you hear about our office?  Yellow Pages  Newspaper  Internet  Sign  Other \_\_\_\_\_  
 Patient (Name) \_\_\_\_\_  Physician (name) \_\_\_\_\_

## Health Information

Are you currently experiencing pain or discomfort  Yes  No

If no, please proceed to page 2

Date when you first noticed symptoms \_\_\_\_\_

What description fits your symptoms?

- Sharp  Throbbing  Dull  Numbness  
 Aching  Shooting  Burning  Tingling  
 Stiffness  Swelling  Cramping  Other

Circle the severity of your pain or discomfort:

(1= mild pain or discomfort; 10 = severe pain)

1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

- Constantly (76 - 100% of the day)  
 Frequently (51 - 75% of the day)  
 Occasionally (26 - 50% of the day)  
 Intermittently (0 - 25% of the day)

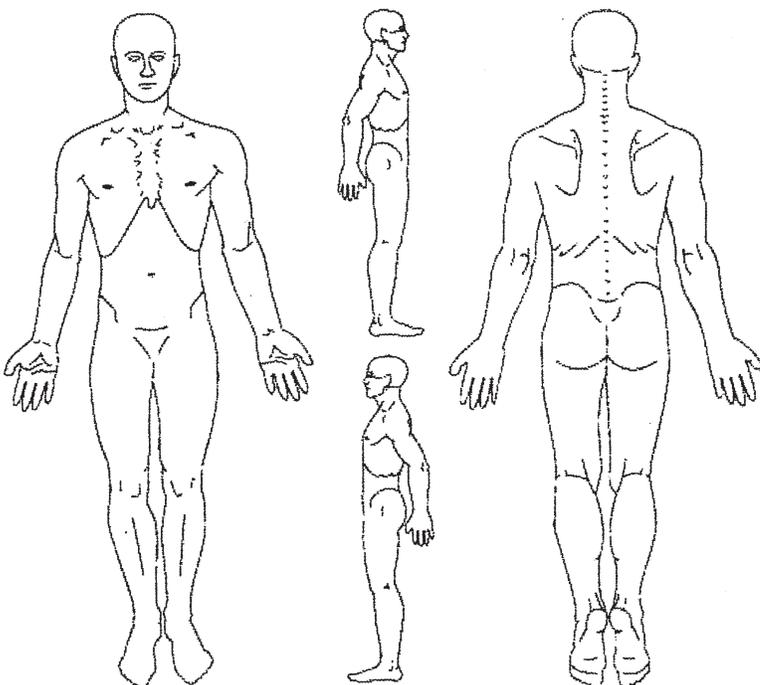
How are your symptoms changing?

- Getting Better  Not Changing  Getting Worse

What treatment have you already received for this?

- Medication  Chiropractic  Physiotherapy  
 Massage Therapy  No treatment to date  
 Surgery Date of Surgery \_\_\_\_\_  
 Other \_\_\_\_\_

Using the diagram mark the location of your pain:



# Lifestyle

How often do you participate in cardiovascular exercise?  Never  1-2 days/wk  3-4 days/wk  Most days  
(walking, running, swimming for 30 minutes)

How often do you perform strengthening exercises?  Never  1-2 days/wk  3-4 days/wk  Most days  
(weight-lifting)

How often do you perform flexibility exercises?  Never  1-2 days/wk  3-4 days/wk  Most days  
(Yoga, Tai Chi, Dance, etc.)

What do your daily work habits include?  Sitting  Walking  Standing  Driving  
 Lifting  Light Labour  Heavy Labour  Computer Work  
 Other \_\_\_\_\_

How do you rate your current stress? (circle) 1 2 3 4 5 6 7 8 9 10  
Low High

Do you eat a healthy diet?  Yes  No How much water do you drink per day? \_\_\_\_\_

Do you smoke?  Yes  No How many cigarettes per day? \_\_\_\_\_ Number of years? \_\_\_\_\_

Do you consume alcohol?  Yes  No If yes, how many drinks per week? \_\_\_\_\_

How many hours of sleep do you get nightly? \_\_\_\_\_ Do you awake feeling rested?  Yes  No

How do you sleep?  Side  Back  Stomach  All

What vitamins or supplements do you take? \_\_\_\_\_

List all medications you are taking: \_\_\_\_\_

List all surgeries and when they occurred: \_\_\_\_\_

# Health History

*Check only those conditions which are applicable*

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Frozen Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Tennis/Golfer's Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Wrist/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Plantar Fasciitis/Heel Spurs	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss	<b>Females</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	HRT
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<b>Any other conditions indicate below:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Tumour	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Coordination	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Hypo/hyper-thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____