Southside Chiropractic: Dr. Don MacDonald / Dr. Hailey Lutz / Dr. Josh Preston / Dr. Kyla Butz

7361 - 104 Street, Edmonton, AB, T6E 4B9, Phone 780-439-3444

Confidential Case History

Date: _____

Please complete the following questionnaire. Your answers will help us to determine if Chiropractic can help you. Thank you!

Name:_____ Date of Birth: _____ Age: _____ Sex: M ◯ F ◯ O ◯

Address:_____ City: _____ Postal Code: _____

Home Telephone #: _____ Cell #: _____ Work #: _____Email: _____

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Alberta Healthcare #: _____

Occupation: _____Name of Business: _____

Emergency Contact Name and number: _____

Referred By: _____

Claim Will Be Made Against:

1. Recent motor vehicle accident? ◯ Yes ◯ No
2. Work related injury/accident (WCB)? ◯ Yes ◯ No WCB #_____

Loss of Health Information:

Reason for attending office: _____

Location of pain:_____

When did you notice it? _____ How often does it occur? _____

Does it radiate? ◯Yes, ◯No If yes, where? _____

What relieves it?_____

What aggravates it? _____

Describe how it interferes with your life, work, or hobbies:_____

_____

When have you had this or similar conditions in the past?_____

Is condition getting worse? ◯Yes, ◯ No ◯ Constant ◯ Comes and Goes

Have you had previous Chiropractic care? ◯ Yes ◯ No

Where?_____ When? _____

Why? _____Were x-rays taken? ◯ Yes ◯ No

Other treatments tried: _____

How long has it been since you felt vital? _____

Past Health History:

Please check if you presently have or have had any of the following conditions in the past:

☐ Blurring of Vision	☐ Bronchitis	☐ Diarrhea	☐ Insomnia
☐ Stroke	☐ Asthma	☐ Stomach Ulcer	☐ Tendonitis
☐ Dizziness	☐ Respiratory condition	☐ Heart Burn	☐ Urinary Frequency
☐ High Blood Pressure	☐ Chest Pains	☐ Headaches	☐ Lower Back Pain
☐ Heart Disease	☐ Diabetes	☐ Allergies	☐ Numbness or Tingling
☐ Aneurysm	☐ Hiatus Hernia	☐ Sinusitis	☐ Migraine Headaches

☐ Varicose Veins ☐ Constipation ☐ Ringing in Ears ☐ Menstrual Problems
☐ Osteoporosis ☐ Heavy Periods ☐ Digestive Problems ☐ Fatigue

Chronic Lifestyle Stressors

Any family health conditions: ◯ Yes ◯ No Please list: _____
Other health problems?
_____
List surgical operations or hospitalizations and years they occurred:
_____
Number of Pregnancies if applicable: _____
Medications?
_____
List and describe any auto accidents or other accidents/injuries:

_____
List and describe any childhood injuries/accidents/hospitalizations/illnesses:

Anything else you feel we should know about?

Draw in your face.
Show area(s) of pain or unusual feeling.
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.

Numbness ● ● ● ● ●
● ● ● ● ●
● ● ● ● ●

Pins & Needles ○ ○ ○ ○ ○
○ ○ ○ ○ ○
○ ○ ○ ○ ○

Burning X X X X X
X X X X X
X X X X X

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /