Southside Chiropractic: Dr. Don MacDonald / Dr. Hailey Lutz
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
TEXT OR EMAIL REMINDERS? NO / YES- text or email? Cell provider: _____
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 / / / / /
/ / / / /