Cookstown Chiropractic 21A Queen Street, Cookstown, ON L0L 1L0

Dr. Mark Trudeau Dr. Jordan Winberg

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us to determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name_____ Birth Date_____ Gender M/F Age_____

Mailing Address_____ City_____

Postal Code_____ Home Phone_____Bus./Cell Phone_____

Marital Status M S W D Spouse's Name_____Children_____

Employer_____ Occupation_____

Name of the person who referred you to our office_____

HEALTH INFORMATION

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar condition in past? _____

What makes it feelbetter?_____

What activities aggravate your condition?_____

Is this condition getting progressively worse?_____

Have you had x-rays of your spine in the past year?_____

Other doctors who have treated this condition:_____

Height_____ (feet/inches) Weight_____(lbs) Shoe Size_____

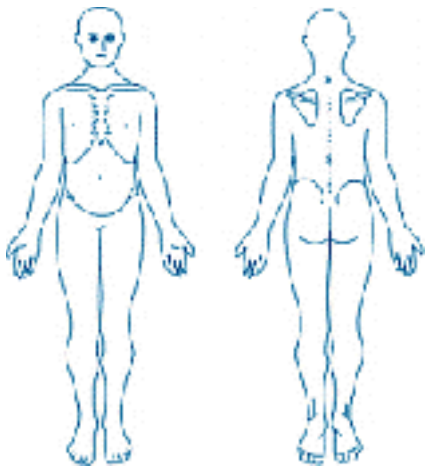
Do you Smoke? Y/N , how much?_____ Do you drink alcohol? Y/N, how much?_____

Have you ever suffered from:

Dizziness	Y N	Heart Trouble	Y N
Backaches	Y N	Diabetes	Y N
Arthritis	Y N	Headaches	Y N
Digestive Disorders	Y N	Sinus Trouble	Y N
Nervousness	Y N		

Other:_____

Please shade/circle areas of pain



Other Complaints?_____

Have you had previous chiropractic care?_____When?_____

Name of Chiropractor _____ Where?_____

Why?_____

Name of your Family Doctor_____ Last Physical Exam_____

List surgical operations and years _____

Do you now take:

Tranquilizers _____ Birth Control Pills _____
Muscle Relaxers _____ Vitamins _____
Pain Killers _____ Pep Pills _____
Insulin _____ Nerve Pills_____

How do you sleep?

On Stomach ____ On Side ____ On Back _____
Age of Mattress _____
Comfortable? _____ Uncomfortable_____
Hours Slept Per Night_____

Are You Wearing:
Heel Lifts _____ Orthotics _____ Inner soles _____ Arch Supports _____

Have you ever been in an automobile accident? Y N
Accident #1 When?:_____ Describe_____
Accident #2 When?:_____ Describe_____

Interests & Hobbies _____

FAMILY HEALTH INFORMATION:

Many health problems are the result of hereditary spinal weaknesses; this information about your immediate family members will give us a better picture of your health.

Have you or a family member had a history of the following?

Asthma _____	Cardiovascular Disease _____	Lumbago _____	M.S. _____
Allergies _____	Learning Disability _____	Diabetes _____	H.I.V. _____
Arthritis _____	Hyperactivity _____	Epilepsy_____	Cancer _____
Alcoholism _____	Stomach Ulcers _____	Bed Wetting_____	Depression _____

Schizophrenia _____
Other _____

I understand and agree that health and accident policies are an arrangement between my insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I consent to the examination by the doctor.

Signature:_____ Date_____

Guardian's Signature _____Witness:_____