



## Addressing The Issues That Brought You To Our Office

If you have no symptoms or complaints, and are here for wellness services, please check here \_\_\_\_\_ I Wish to Have Chiropractic Wellness Services. Others need to briefly describe the chief complaint, including the effect it has had on your life.

HAS THIS PROBLEM HAPPENED BEFORE?  Yes  No If YES, when and how many times \_\_\_\_\_

IF YOU ARE EXPERIENCING PAIN, IS IT...  sharp  dull  achy  pins & needles  numb  burning

SINCE THE PROBLEM STARTED, IS IT GETTING...  worse  better  constant  intermittent (comes & goes)

WHAT MAKES IT WORSE?  sitting  standing  bending  lifting  walking  other \_\_\_\_\_

WHAT MAKES IT BETTER?  bed rest  ice  heat  chiropractic  medication  other \_\_\_\_\_

HOW DOES THIS AFFECT THE FOLLOWING AREAS OF YOUR LIFE?

Family life \_\_\_\_\_ Work \_\_\_\_\_ Sports/Hobbies \_\_\_\_\_

Other doctors/therapists seen for this condition:  Yes,  No What type? \_\_\_\_\_

Is this a work-related injury?  Yes  No (we are not a WCB provider)

On a scale of 1 to 10 (10 being the highest) rate your commitment to correcting this problem? \_\_\_\_\_

Have you had previous chiropractic care?  Yes  No

Name of previous chiropractor \_\_\_\_\_ How long ago? \_\_\_\_\_

### CHECK ANY OF THE FOLLOWING YOU HAVE HAD, EVEN IF THEY DO NOT SEEM RELATED TO YOUR CURRENT PROBLEM

High blood pressure

Heart problems

Chest pain

Stroke

Irregular heartbeat

Gallbladder problems

Vision problems

Hearing problems

Earaches

Excessive thirst

Vomiting

Nervousness

Headaches

Fatigue

Dizziness

Cold/tingling

arms/legs/hands/feet (circle)

Poor/excessive appetite

Ringing/buzzing in ear

Epilepsy

Tuberculosis

Cancer

Mental disorder

Anemia

Stomach upset/gas/bloating

Nausea

Diarrhea/Constipation (circle)

Walking problems

Joint pain/stiffness

Sleeping problems

Loss of balance

Depression

Mood Swings

Urination problems

Bladder problems

Menstrual irregularity/Cramps

Hot Flashes

Back pain

Neck pain

Eczema

Arthritis

Diabetes

Clicking Jaw

Asthma

Irritability

Fainting

Cold sweats

Allergies

FAMILY HISTORY –	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have health care benefits?  Yes  No

#### PLEASE READ THE FOLLOWING CAREFULLY

I understand and agree that health and/or accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and/or receipts to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment each visit unless arrangements have been made with this centre. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_