Confidential Case History

Date:_____

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

First Name: _____ Last Name:_____

Preferred Name: _____ Date of Birth: M / D / Y Age:_____ Sex: ☐ M ☐ F ☐ O

Alberta Healthcare #:_____

Address:_____City:_____ Postal Code: _____

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

Email:_____

I consent to receive emails from Whitemud Crossing Chiropractors for the purpose(s) of:

☐ Appointment reminders & receipts *and/or* ☐Clinic Newsletters * *I understand my consent may be withdrawn at any time.*

Marital Status: ☐ Single ☐ Married ☐ Common- law ☐ Divorced ☐ Widowed

Are you currently pregnant? ☐ Yes If yes, how many weeks? _____

Number of Children:_____ Children's Names (Ages):_____

Occupation: _____ Name of Business:_____

Emergency Contact Name, number, and relationship:_____

How did you hear about us? ☐ Google ☐Walked by☐Facebook/Instagram ☐Family/Friend _____

Claim Will Be Made Against:

1. Recent motor vehicle accident? Yes ☐ No ☐ 2. Work related injury/accident? Yes ☐ No ☐

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

Rate the pain 0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe Worse possible pain

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 really felt good? _____

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	in Arms or Legs
☐ Varicose Veins	☐ Constipation	☐ Ringing In Ears	☐ Menstrual Problems
☐ Osteoporosis			

Any family health conditions: ☐ Yes ☐ No Please list:_____

Other health problems? _____

_____

List surgical operations or hospitalizations and years they occurred: _____

_____

Previous Pregnancies _____

List of medications you now take: _____

_____

Rate your diet:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your sleep habits:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your exercise:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your mental state:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent

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.

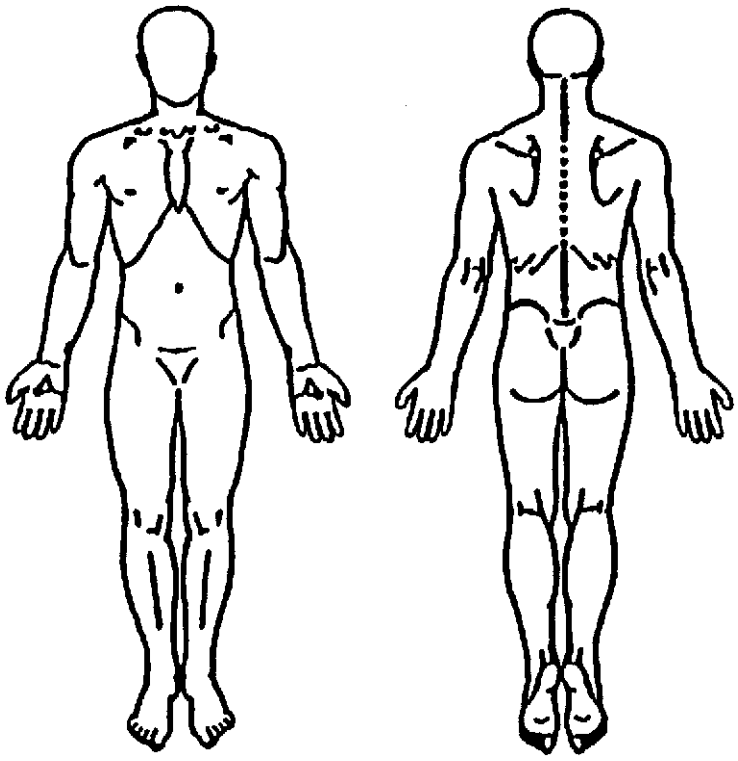
Numbness ● ● ● ● ●
● ● ● ● ●
● ● ● ● ●

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

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

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

Stabbing / / / / /
/ / / / /
/ / / / /



Reviewed and discussed with patient name:_____ by chiropractor _____