

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: MM - DD - YYYY Age: _____ Gender: M F U | Sex: M F

Alberta Healthcare #: _____ Email: _____

Address: _____ City: _____ Postal Code: _____

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

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: _____ Emergency Contact #: _____

How did you hear about us? Google Walked by Facebook/Instagram
 Family/Friend (name) _____ Other: _____

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:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Blurring of Vision | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Respiratory condition | <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Urinary Frequency |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Numbness or Tingling
in Arms or Legs |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Hiatus Hernia | <input type="checkbox"/> Sinusitis | |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Constipation | <input type="checkbox"/> Ringing In Ears | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Osteoporosis | | | |

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Any family health conditions: No Yes: _____

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? _____

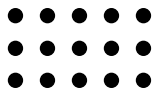
Draw in your face.

Show area(s) of pain or unusual feeling.

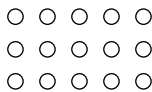
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.

Mark areas of radiation. Include all affected areas.

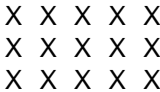
Numbness



Pins & Needles



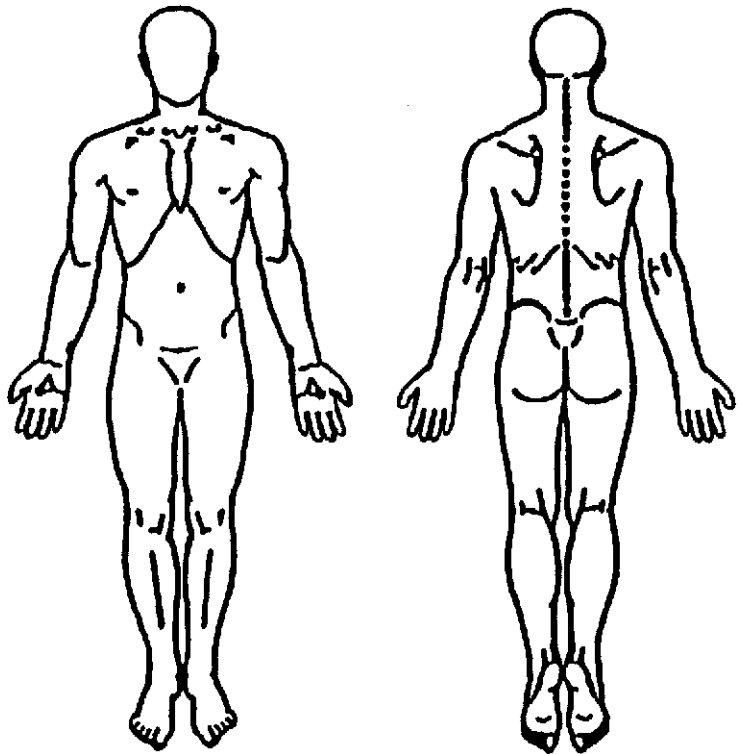
Burning



Aching



Stabbing



Reviewed and discussed with patient: _____ by chiropractor _____