OPTIMAL CHIROPRACTIC

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The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods. Please complete this confidential health questionnaire fully and accurately. The more we know about the overall picture of your health, the better we will be able to help you. Doctors of Chiropractic are trained to detect and correct vertebral subluxations. Please respond to this questionnaire thoroughly, to help us determine potential causes and effects of subluxations in your case. If you have any questions please don't hesitate to ask one of our chiropractic assistants for guidance.

Patient Information

First Name: _____ **Middle Initial**: ____ **Last Name**: _____

Street Address:_____ **City**:_____ **Prov**:_____ **Postal Code**:_____

Home:_____ **Cell**:_____ **Work**:_____ **EXT**:_____

Email:_____

Care Card Number:_____ **Birthdate**: (m/d/yr) _____**Age**: ____ **Height**: ____**Weight**: ___

Gender: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Common Law ☐ Widowed

Name of Spouse/Significant Other:_____

My Occupation:_____ **Employer**:_____

Previous Chiropractic Care

Have you ever been adjusted by another Chiropractor?

☐ Yes ☐ No

If yes, Chiropractors Name:_____

Reason for seeing previous Chiropractor:_____

_____

Were X-rays taken? ☐ Yes ☐ No

When was your last spinal X-rays taken? _____

Did your family receive chiropractic care?

☐ Yes ☐ No ☐ N/A

Who can we thank for this referral?

☐ Patient from this office (name)

_____

☐ Other Health Care Professional (name)

_____

☐ Walk By

☐ Website

☐ Sign

☐ Google

☐ Other internet search engine

☐ Other (specify) _____

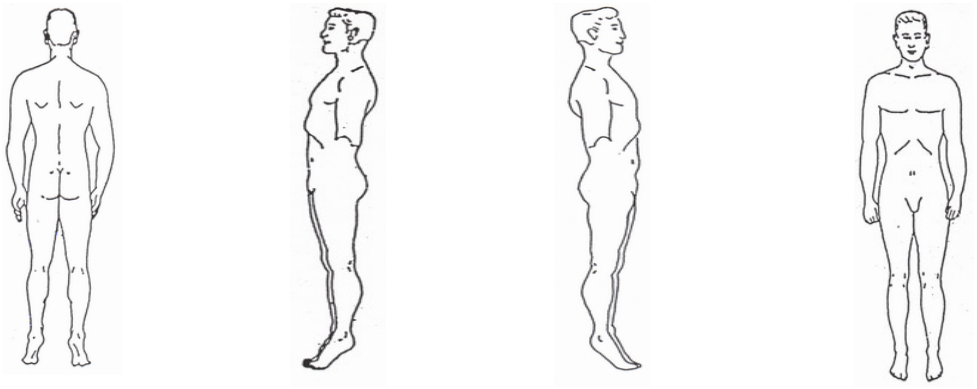
What is the purpose of this appointment? Describe in detail: _____

_____

_____

_____

Please indicate (circle) on the diagram below the area (s) in which you are experiencing problems.



Is the purpose of this appointment related to

☐ Work ☐Stress ☐ Sports ☐ Auto ☐ Fall ☐ Chronic Discomfort ☐ Repetitive Trauma ☐ Check-Up ☐ Other

Please explain _____

_____

How long have you had this condition? _____ Have you had this or similar conditions in the past? (When?)_____

What activities aggravate your condition? _____

Is there anything that relieves the symptoms? _____

Has this condition: ☐ gotten worse ☐ stayed constant ☐ comes and goes ☐ improving

Does this condition interfere with ☐ work ☐ sleep ☐ daily routine ☐ childcare responsibilities ☐ sports ☐ other activities (explain)

_____

_____

On a scale of 0 to 10 (with 0 being no pain, and 10 being the worst pain, rate your concerns by **circling the number**.

0 1 2 3 4 5 6 7 8 9 10

Have you ever had an X-ray, CT Scan, MRI, Bone Scan? ☐ Yes ☐ No (If yes, Where?) _____ (When?) _____

What were the results? _____

_____

Have you seen any other care providers for this condition? ☐ Yes ☐ No (If yes, explain)_____

_____

Practitioner's Name _____ Type of Care _____

Date _____ Results _____

Injuries:

Have you ever broken a bone (s)? ☐ Yes ☐ No _____

_____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐ Yes ☐ No

_____

_____

Sprains, strains, dislocations (give details and how long ago): _____

_____

Surgical operations (give details and how long ago): _____

_____

Have you ever been hospitalized for any other reason? ☐ Yes ☐ No (give details): _____

_____

_____

My Health Conditions

Please check on the box for the conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, care plan, and the possibility of being accepted for care or referred to another practitioner, if necessary.

General

☐ - Allergy
☐ - Convulsions
☐ - Dizziness/Vertigo
☐ - Fatigue
☐ - Headache
☐ - Migraines
☐ - Loss of sleep
☐ - Loss of weight
☐ - Cancer:_____
_____
☐ - Numbness
☐ - Anxiety
☐ - Depression
☐ - Diabetes
☐ - Thyroid problems
☐ - Epilepsy
☐ - Hyperactivity
☐ - Gout
☐ - Polio
☐ - Poor posture
☐ - Swollen Joints
☐ - Fractures:_____
_____

Numbness or pain in:

☐ - Shoulder
☐ - Upper Arms
☐ - Hands
☐ - Legs
☐ - Feet

Gastro-Intestinal

☐ - Liver trouble
☐ - Constipation
☐ - Diarrhea
☐ - Digestive dysfunction
☐ - Gall bladder trouble
☐ - Hemorrhoids
☐ - Ulcers

Cardio-Vascular

☐ - High blood pressure
☐ - Low blood pressure
☐ - Poor circulation
☐ - Irregular heart beat
☐ - Anemia
☐ - Arteriosclerosis
☐ - Stroke
☐ - Ankle swelling

Eyes, Ears, Nose and Throat

☐ - Asthma
☐ - Frequent colds
☐ - Crossed eyes
☐ - Deafness
☐ - Ear infections
☐ - Ringing in the ears
☐ - Eye pain
☐ - Vision problems
☐ - Nasal obstruction
☐ - Sinus Problems
☐ - Jaw Problems

Muscle and Joint

☐ - Arthritis
☐ - Hernia
☐ - Low back pain
☐ - Neck pain
☐ - Pain between shoulder blades
☐ - Rib Pain Left / Right
☐ - Disc Herniation
☐ - Sciatic
☐ - Knee Pain
☐ - Ankle Pain
☐ - Other (not listed):_____

Respiratory

☐ - Chest pain
☐ - Chronic cough
☐ - Irregular breathing
☐ - Wheezing
☐ - Emphysema

Genito– Urinary

☐ - Bed-wetting
☐ - Painful urination
☐ - Prostate trouble
☐ - Blood in urine

Women Only

☐ - Menstrual cramps
☐ - Excessive menstruation
☐ - Irregular cycle
☐ - Hot flashes

Are you pregnant? ☐ Yes ☐ No

If Yes: Expected due Date:

_____

SOURCES OF SPINAL STRESSES

To help us determine the cause of your problem, please indicate, on this page and the next, potential sources of spinal trauma.

General Physical Trauma

(Details and Dates)

☐ As infant or child _____
☐ Down stairs _____
☐ On ice _____
☐ Sports impact _____
☐ Physical fight _____
☐ Other _____

Primary Daily Activities

☐ sitting ☐ standing ☐ walking ☐ desk work ☐ telephone
☐ driving ☐ manual repetitive work ☐ heavy lifting

Exercise

☐ heavy/daily ☐ moderate/recreational ☐ Periodic

Describe_____

Auto Accidents

Have you ever, even as a passenger, even if you did not think you were hurt, been involved in a car accident? ☐ Yes ☐ No

If yes, please indicate approximate dates and severity below :

_____

If your chief complaint is in direct response to a motor vehicle accident, please notify our staff, as we will require a separate questionnaire to document your accident and injury.

History of Chemical Stress

Medication I am presently taking

☐ Pain Killers _____

☐ Anti-inflammitories _____

☐ Muscle Relaxants _____

☐ Blood Pressure Medications _____

☐ Stimulants _____

☐ Anti-depressants _____

☐ Tranquillizers, Anti-anxiety _____

☐ Blood Thinners _____

☐ Birth Control Pills _____

☐ Other _____

_____

Health Habits

	Heavy	Moderate	Light	None
Tobacco	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐

	Good	Fair	Poor	None
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Personal Stress Levels

	Good	Fair	Poor
Past	☐	☐	☐
Present	☐	☐	☐

Fee Schedule:

Initial Consultation Fee: $56.00

Subsequent Visit Fee: $45.00

X-ray Fee: $89.00

I, the undersigned, understand that services rendered in this office are responsibility of myself should Medical Services Plan or other third party plans fail to pay all or part of the amount due. I understand 24 hours notice is requested for cancellation of an appointment. I, the undersigned, also understand that each Practitioner is an independent and separate practice operating under Optimal Chiropractic and Massage Therapy Clinic. I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary. In the event that X-rays are necessary in my case, I understand and agree that X-rays taken in this clinic are the property of Optimal Chiropractic Clinic, and will remain in this clinic where they can be reviewed for me by the Doctors. I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable.

Patient's Signature_____ **Date** _____

(or signature of guardian or spouse authorizing care)