New Patient Case History

We are pleased that you have chosen to consult us regarding your health. In order to help us evaluate your condition thoroughly, please complete the following form. This information is important so we ask that you be accurate. Please ask for assistance if needed.

Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F

Address:_____

City: _____ Province: _____ Postal Code: _____

Telephone Number:_____

Occupation: _____ Business Telephone:_____

Check One: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Partner's Name:_____Number of Children: _____

Referred to our office by:_____

Current Health Condition:

Area of main problem: _____

_____

_____

When did this condition begin? _____

Is it getting ☐ Better? ☐ Worse? ☐ Staying the Same? ☐ Comes and Goes?

Have you had this before? ☐ Yes ☐ No If Yes, When?_____

Have you had treatment for this or previous episode? ☐ Yes ☐ No

If Yes, Where?_____

What aggravates your problem? _____

What alleviates it? _____

Is the problem: ☐ Constant? ☐ Intermittent?

Your Medical Doctor's Name: _____

List any Medications or Vitamin Supplements you presently take: _____

_____

_____

Do you suffer from any condition other than that which you are now consulting us? _____

_____

_____

(see other side)

BARTON Chiropractic CENTRE

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Past Health History:

List any surgery, accidents and falls, including year: _____

_____

_____

Have you ever had Chiropractic Care? ☐ Yes ☐ No

If yes, when? _____ Where?_____

For what condition? _____

Were X-rays taken? ☐ Yes ☐ No ☐ Not Sure

Women: Date of last menstrual cycle (start date): _____

Are you pregnant? ☐ Yes ☐ No ☐ Not Sure

Have you ever had or been treated for any of the following conditions? ***Please check all that apply.***

☐ Alcoholism	☐ Emphysema	☐ Psoriasis
☐ Anemia	☐ Epilepsy	☐ Rheumatic Fever
☐ Arthritis	☐ Heart Disease	☐ Small Pox
☐ Cancer	☐ Measles	☐ Stroke
☐ Chicken Pox	☐ Mental Disorders	☐ Thyroid Problems
☐ Diabetes	☐ Mumps	☐ Tuberculosis
☐ Diptheria	☐ Pneumonia	☐ Venereal Disease
☐ Eczema	☐ Polio	☐ Whooping Cough

How much of the following do you consume daily?

Cups of Coffee _____ Cigarettes _____

Cups of Tea _____ Alcohol _____

Do you skip meals? ☐ Occasionally ☐ Frequently

Do you exercise? ☐ Yes ☐ No Amount per week?_____

Family History:

Many health problems are the result of hereditary spinal weaknesses, thus, information about your family members will give us a better picture of your total health. Please list any family member who has or had any health problems.

_____

_____

_____

_____

People go to Chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to correct the underlying cause of the problem, to increase their health potential and prevent the problem from returning. Please check which type of care you are seeking:

☐ Correction ☐ Relief Care ☐ Wellness