Martin Chiropractic Clinic
57 Albert Street
Waterloo, ON
N2L 3S1
(519) 886-2570
www.martinchiro.ca

Date: _____

CASE HISTORY UPDATE

Welcome back! In order for us to best serve you, we need to bring your original case history up to date. Please provide the following information:

Name _____ E-mail _____
(As it appears on your Health Card)
Address _____ City _____ Postal _____

Phone #'s → home _____ work _____ cell _____

Date of Birth _____ Occupation _____Employer_____

Spouse's Name _____ # of children _____ ages _____

Where was your last chiropractic treatment? _____

What was the date of your last chiropractic treatment? _____

For what condition? _____

What do you believe caused it? _____

How long have you had this condition? _____

Since your last visit here, have you consulted another doctor for this condition? _____

If yes, for what condition? _____ Drs' name _____

And what treatment did your receive? _____

Please provide any other information the doctor should know regarding your present condition. _____

Please complete the other side

Pain (s) are: Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐ Worsening ☐ Improving ☐

What activity aggravates your current condition/pain? _____

What activities lessens your condition/pain?

_____

Is condition worse during certain times of the day? Yes ☐ No ☐ When? ☐ _____

Is condition interfering with work? ____ Sleep? ____ Routine? ___ Other? _____

Have you tried any home remedies for this problem? If so, what? _____

Please indicate ✔any other symptoms you are or have experienced:

Symptom	Have Now	Had In the Past		Symptom	Have Now	Had In the past		Symptom	Have Now	Had In the Past
Headache				Neck Pain				Fainting		
Upper Back Pain				Pins & Needles in Arms				Pins & Needles in Legs		
Numb Fingers				Loss of Taste				Low Back Pain		
Nervousness				Diarrhea				Chest Pain		
Ears Ring				Cold Feet				Depression		
Fatigue				Cold Hands				Tension		
Lights bother Eyes				Upset Stomach				Loss of Memory		
Irritability				Constipation				Fever		
Numb Toes				Cold Sweats				Dizziness		
Shortness Of Breath				Loss of Balance				Loss of Smell		
Ears Buzz				Sinus				Respiratory Problems		

Have you undergone any type of surgery? ☐ Yes ☐ No What?_____

When?_____ Are you currently under any drug/medical care? _____

_____

Is there a history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's side	☐	☐	☐	☐	☐ _____
Mother's side	☐	☐	☐	☐	☐ _____

Signature:_____