PERSONAL HISTORY

Date: _____ Do you have an Extended Health Care plan? Yes/No
(select one) : Blue Cross, Manulife, Sunlife, Great West Life
Other: _____

Name: _____ Alberta Health Care: _____

Mailing Address: _____

City: _____ Province: _____ Postal Code:_____

Phone: Home _____ Business: _____ Cell: _____

Email Address:
_____
(used for appt reminders, invoices, receipts, birthday cards)

Date of Birth: _____ Age: _____
Day/Month/Year

Sex: ☐ Male ☐ Female Height: _____ Weight: _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Common Law

Business Employer: _____ Type of Work: _____

Spouse's Name: _____ Children's Names: _____

Referred to this office by:
_____

Previous Chiropractic Experience: Location: _____ Date:_____

Emergency Contact Name : _____
Phone:_____

Relationship to Patient: _____

Is this injury a result of a Motor Vehicle Accident? ☐ Yes ☐ No
If yes: Date of Accident: _____

Is this injury the result of a work place injury? ☐ Yes ☐ No
If yes: Date of injury: _____

Have you reported this injury to your Employer? ☐ Yes ☐ No

YOUR HEALTH PROFILE

Reason for consulting the office:

_____

_____

When did this condition begin?_____

Have you had this condition before? ☐ Yes ☐ No

Has this condition: ☐ Gotten Better ☐ Gotten Worse ☐ Stayed the Same ☐ Comes & Goes

Does this condition interfere with: ☐ Work ☐ Sleep ☐ Daily Routine

Have you seen anyone else for this condition? ☐ Yes ☐ No

Type of treatment: _____
Practitioners Name: _____
Results: _____

Please mark each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of this appointment they can affect the overall diagnosis and care plan.

- ○ Stroke
- ○ Headaches
- ○ Sinus Problems
- ○ Heart Murmur
- ○ High/Low Blood Pressure
- ○ Chemotherapy
- ○ Psychiatric Problems
- ○ Neck Pain
- ○ Digestive Problems
- ○ Arthritis
- ○ Heart Attack
- ○ Congenital Heart Defect
- ○ Heart Surgery/Pacemaker
- ○ Hepatitis
- ○ Cancer: _____
- ○ Rheumatic Fever
- ○ Difficulty Breathing
- ○ Low Back Pain
- ○ HIV/AIDS
- ○ Ulcers
- ○ Diabetes
- ○ Shingles
- ○ Kidney Problems
- ○ Dizziness
- ○ Loss of Sleep
- ○ Pain Between Shoulders
- ○ Asthma
- ○ Numbness or Tingling in Arms/Hands/ Legs
- ○ Tuberculosis
- ○ Other: _____

Medications you may be taking: ☐ Stimulants ☐ Blood Thinners ☐ Muscle Relaxants

☐ Painkillers ☐ Insulin ☐ Blood Pressure Medication ☐ Other:_____

On a scale of 1-10 describe your stress level (1: none 10: extreme)
Personal _____ Occupational: _____
On a scale of good/poor/excellent describe:
Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

Women:
Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Do you have painful menstruation? ☐ Yes ☐ No
Do you experience irregular cycles? ☐ Yes ☐ No