NEW PATIENT INFORMATION

NAME:_____ Date of Birth:_____ Age:___

HOME # ( )_____ WORK # ( ) _____ CELL # ( )_____

ADDRESS:_____
RESIDENCE AND MAILING CITY PROV POSTAL CODE

EMPLOYER:_____ OCCUPATION:_____

ALBERTA HEALTH CARE NUMBER: _____

INSURANCE INFO:_____
(Patient is responsible for all costs not covered by insurance company and not paid directly to Camrose Chiropractic Clinic)

SINGLE___ MARRIED___ DIVORCED___WIDOWED___ SPOUSE NAME_____ NO. OF CHILDREN:_____

EMAIL ADDRESS:_____

HOW DID YOU HEAR ABOUT US? REFERAL (WHO?)_____ _____ _____PHONE BOOK___WEBSITE___

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

In our clinic, we focus on your ability to be healthy. Our goals are, first to address the issues that brought you to this office, and second to offer you the opportunity of improved health and wellness in the future. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

YOUR CHILDHOOD YEARS (TO AGE 17) YES / NO / UNSURE

Did you have any childhood illnesses?

Were you involved in any car accidents as a child?

Did you have any serious falls as a child?

Were there any prolonged use of medicine such as antibiotics or an inhaler?

Did you play youth sports?

Did you have any surgery?

Did you suffer any other traumas (physical or emotional)?

Did you take / uses any drugs

Were you vaccinated?

As a child, were you under regular Chiropractic care?

YES / NO / UNSURE

Have you fallen / jumped from a height over three feet? (i.e.crib, bunk bed, trees)

ADULT – (18 TO PRESENT) YES / NO

Do / did you smoke?

Have you had any surgery?

Do / did you drink alcohol?

Do / did you participate in extreme sports?

Do / did you play any adult sports?

Have you been in any accidents(motor vehicle, work place or other)? If yes,

1) How many? _____

2) Approximate dates?_____

On a scale of 1 – 10 describe your : Occupational Stress:_____

Personal Stress:_____

On a scale of: Poor, Good, or Excellent describe your:

DIET:_____ EXERCISE:_____ SLEEP:_____ GENERAL HEALTH:_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THIS OFFICE

1. Briefly describe the chief area(s) of complaint, including the effect it has had on your life?_____

_____

2. Pain is: Sharp_____ Dull_____ Comes and goes_____ Travels_____ Constant_____

3. Has this condition: gotten better_____ gotten worse_____ Stayed the same_____ comes and go _____

4. What makes it worse? _____

5. Does it interferes with: Work:_____Sleep:____ Walking:___ Sitting: _____Hobbies:_____ Leisure:____

6. Other Doctors seen for this problem (please list):
Chiropractor:_____ Medical Doctor:_____ Other:_____

7. PREVIOUS X-RAY_____

8. Have you ever had therapeutic massage before? Yes / No

(Woman only) Are you pregnant? Yes/No Date of onset of last menstrual cycle_____

Please circle all symptoms you have experienced (circle P for Past, C for Current), even if they do not seem related to your current problem.

P C Headaches	P C Pins and needles in legs	P C Fainting
P C Dizziness	P C Pins and needles in arms	P C Ringing in ears
P C Numbness in fingers	P C Diarrhea	P C Irritability
P C Numbness in toes	P C Loss of Smell	P C Cold Hands
P C Fatigue	P C Buzzing in Ears	P C Cold Feet
P C Sleeping Problems	P C Neck Stiff	P C Fever
P C Depression	P C Constipation	P C Menstrual Irregularity
P C Neck Pain	P C Loss of Taste	P C Menstrual Pain
P C Tension	P C Light bothers eyes	P C Problem Urinating
P C Cold Sweats	P C Nervousness	P C Stomach Upset

List any medications you are taking now for any reason:_____

_____

Have you ever……. Belonged to a health Club: Y / N

Consumed vitamins or supplements: Y / N

Patient Signature_____ Date: _____

The Center for Health

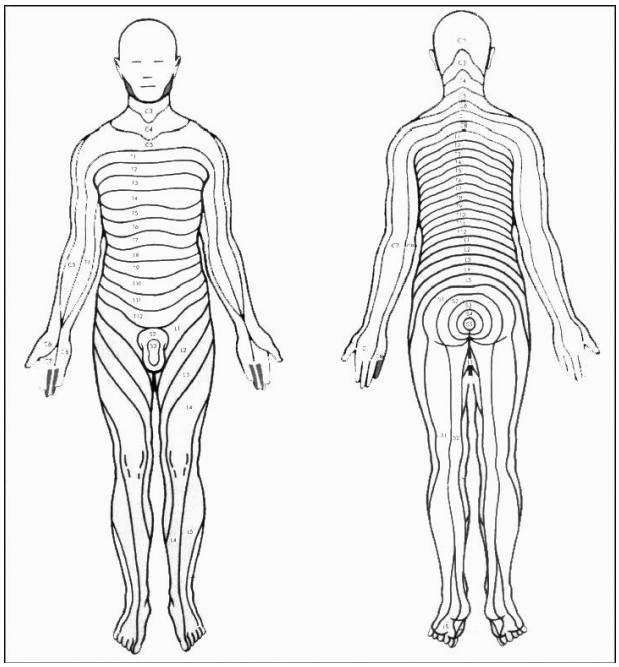
Family History: Please indicate **M=Mother F=Father S=Sister B=Brother GP=Grandparent**

High Blood Pressure [M][F][S][B][GP]
Heart Disease [M][F][S][B][GP]
Thyroid Disease [M][F][S][B][GP]
Kidney Disease [M][F][S][B][GP]
Diabetes [M][F][S][B][GP]
Parents living/good health [M][F]
Asthma [M][F][S][B][GP]
Migraine [M][F][S][B][GP]
Seizures [M][F][S][B][GP]
Anemia [M][F][S][B][GP]
Arthritis [M][F][S][B][GP]
Cancer[M][F][S][B][GP]
Parent deceased [M][F] Age:_____**Cause:**_____
Remarks:_____
_____
_____

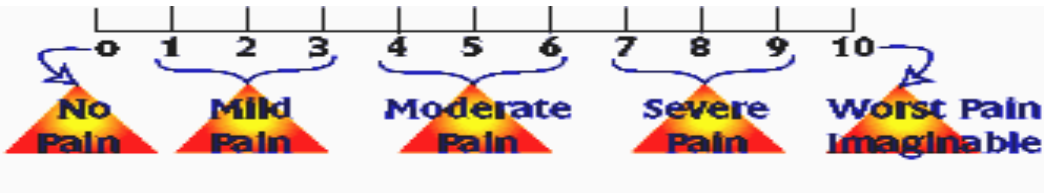
1. If you are not feeling any symptoms and are seeking wellness care please check here: ☐

2. Please use the body diagram beside to describe your symptoms. Mark all affected areas using the symbols below on the person in the diagram.

Numbness: ……..
……..
Pins & Needles: OOOOO
OOOOO
Burning: XXXXX
XXXXX
Aching: *******
****
Stabbing: ////////////
////////////



Please rate the pain you are feeling right now by drawing a star (*) on the scale below.



Don't forget to sign up at www.spine.ca for health tips and monthly Chiropractic Newsletters.