Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!

Name____ Date____

E-mail_______________________________ Home Phone ___________________ Work Phone __________________

Address _____________________________ City ________________________ Province _____________ PC __________

Date of Birth ____/____/____ F☐ M☐ Marital Status _________ # of children ___________

Spouse ________________________ Referred by ____________________ Occupation ___________________

PLEASE NOTE: WE ARE *AUTHORIZED WORKERS' COMPENSATION BOARD (WCB) PROVIDERS.

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O-OCCASSIONAL **F**-FREQUENT **C**-CONSTANT

O	F	C	
☐	☐	☐	Headaches
☐	☐	☐	Pins and needles in arms
☐	☐	☐	Pins and needles in legs
☐	☐	☐	Dizziness
☐	☐	☐	Fatigue
☐	☐	☐	Sleeping problems
☐	☐	☐	Diarrhea
☐	☐	☐	Cold sweats
☐	☐	☐	Mood swings
☐	☐	☐	Allergies
☐	☐	☐	Poor posture
☐	☐	☐	Loss of smell
☐	☐	☐	Loss of taste
☐	☐	☐	Buzzing in ears
☐	☐	☐	Ringing in ears
☐	☐	☐	Depression
☐	☐	☐	Stiff neck
☐	☐	☐	Neck pain
☐	☐	☐	Pain between shoulders
☐	☐	☐	Constipation

O	F	C	
☐	☐	☐	Lights bother eyes
☐	☐	☐	Menstrual pain
☐	☐	☐	Menstrual irregularity
☐	☐	☐	Heartburn
☐	☐	☐	Ulcers
☐	☐	☐	Difficult digestion
☐	☐	☐	Fainting
☐	☐	☐	Back pain
☐	☐	☐	Irritability
☐	☐	☐	Nervousness
☐	☐	☐	Tension
☐	☐	☐	Hot flashes
☐	☐	☐	Bursitis
☐	☐	☐	Loss of balance
☐	☐	☐	Stomach upset
☐	☐	☐	Numbness in arms/fingers
☐	☐	☐	Numbness in feet/toes
☐	☐	☐	Cold hands
☐	☐	☐	Cold feet
☐	☐	☐	Fever

O	F	C	
☐	☐	☐	Spinal curvature/scoliosis

Are you pregnant ?

Yes No

Pain or numbness

☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Sciatica

CHECK THE FOLLOWING CONDITIONS IF YOU HAVE HAD

☐ Alcoholism	☐ Arthritis	☐ Cancer
☐ Diabetes	☐ Gout	☐ Heart Condition
☐ Multiple Sclerosis	☐ Stroke	☐ Other

Have you ever had previous chiropractic care? ___________If yes, date of last care:______________________________

Is this an accident that happened on the job? ☐ Yes ☐ No

PLEASE PRINT

What is your major complaint?____
____
____
Other complaints:____
How long have you had this condition? __________ Have you had this or similar conditions in the past? _____________
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes
Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other:______________
How long has it been since you last felt really good? ____
List previous diagnoses and treatments you have received for present conditions:______________________________
____
What do you believe is wrong with you?____
List surgical operations and years:____
____
Drugs you now take: ☐Nerve pills ☐Painkillers ☐Muscle relaxants ☐"Pep" pills
☐Tranquilizers ☐Birth Control ☐Other:____________________________________
Age of Mattress:_________ ☐Comfortable ☐Uncomfortable
Are you wearing? ☐Heel lifts ☐Sole lifts ☐Inner soles ☐Arch supports
Have you been in an auto accident? ☐Past Year ☐ Past five years ☐Over five years ☐Never
Describe:____

HAVE YOU EVER:	**YES**	**NO**	**DESCRIBE BRIEFLY**
Been knocked unconscious?	☐	☐	____
Used a cane, crutch, or other support?	☐	☐	____
Been treated for a spine or nerve disorder?	☐	☐	____
Had a fractured bone?	☐	☐	____
Been hospitalized for other than surgery?	☐	☐	____

DATE OF LAST:	**Less than 6 months**	**6-18 months**	**Over 18 months**	**Never**
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine Test	☐	☐	☐	☐
HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend with different phone number)
Name:____
Address:____Phone:__________________________