50th Street Chiropractic Clinic

Suite 206 - 12781 50th Street, Edmonton, Alberta, T5A 4L8
Phone (780) 414-1110 Fax (780) 760-1112

Confidential Patient Case History

Name_____ Date_____
Address _____ City _____ Province _____ POSTAL CODE _____
Ph: (H) _____ (C) _____ (W) _____
E-mail (*Optional*)_____ Marital Status _____ Spouse _____
Sex: F ☐ M ☐ Other ☐ Date of Birth _____ # of children ___ Occupation _____

Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office?
_____
Appointment Reminders: Reminder Type: Text or Email _____
Allow our clinic to send email on Educational/Health Materials YES ☐ NO ☐

*Please note: We are AUTHORIZED WORKERS' COMPENSATION BOARD (WCB) Providers. Is this work related? ☐ Yes ☐ No
When was the Accident? _____ Employer: _____ Ph

Have you been in a motor vehicle accident? ☐ Past Year ☐ Past five years ☐ Over five years ☐ Never
Describe: _____

Stress has a negative impact on our health. Are you under more than a normal amount of stress in your life? YES ☐ NO ☐

When was your last treatment? Chiropractic: _____ Physiotherapy: _____ Massage: _____ Acupuncture: _____

What is your major complaint? _____

On a scale of 1 to 10, how would you rate your overall discomfort? (0= no pain, 10= most pain) _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? YES ☐ NO ☐

List previous testing, x-rays, diagnoses and treatments you have received for the major complaint: _____
_____
_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes
Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other: _____
Have you recently had: ☐ Fever ☐ Chills ☐ Night Sweats ☐ Infection OR ☐ Other illness: _____
Do you have pain or difficulties/weakness with your: ☐ Hips ☐ Legs ☐ Feet ☐ Arms

Other complaints: _____

How long has it been since you felt really good? _____

CHECK THE FOLLOWING CONDITIONS IF YOU HAVE HAD

☐ Alcoholism ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Gout ☐ Heart Condition ☐ Multiple Sclerosis ☐ Stroke
☐ Low Bone Density ☐ Other(s) _____

HAVE YOU EVER:	YES	NO	DATE AND DESCRIBE
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine/nerve disorder?	☐	☐	_____
Fractured any bone incl from minor trauma?	☐	☐	_____
Had surgery/operation?	☐	☐	_____
Been hospitalized?	☐	☐	_____

Please check the box(s) **ONLY that APPLY** *to you 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-OCCASIONAL* **F**-FREQUENT* **C**-CONSTANT*

O	F	C		O	F	C		O	F	C	
☐	☐	☐	Headaches	☐	☐	☐	Pain between shoulders	☐	☐	☐	Cold feet
☐	☐	☐	Pins and needles in arms	☐	☐	☐	Constipation	☐	☐	☐	Fever
☐	☐	☐	Pins and needles in legs	☐	☐	☐	Lights bother eyes	☐	☐	☐	Spinal curvature/scoliosis
☐	☐	☐	Dizziness	☐	☐	☐	Menstrual pain				
☐	☐	☐	Fatigue	☐	☐	☐	Menstrual irregularity				Are you pregnant?
☐	☐	☐	Sleeping problems	☐	☐	☐	Heartburn				Yes No
☐	☐	☐	Diarrhea	☐	☐	☐	Ulcers				
☐	☐	☐	Cold sweats	☐	☐	☐	Difficult digestion				**Pain or numbness**
☐	☐	☐	Mood swings	☐	☐	☐	Fainting	☐	☐	☐	Shoulders
☐	☐	☐	Allergies	☐	☐	☐	Back pain	☐	☐	☐	Arms
☐	☐	☐	Poor posture	☐	☐	☐	Irritability	☐	☐	☐	Elbows
☐	☐	☐	Loss of smell	☐	☐	☐	Nervousness	☐	☐	☐	Wrists
☐	☐	☐	Loss of taste	☐	☐	☐	Tension	☐	☐	☐	Hands
☐	☐	☐	Buzzing in ears	☐	☐	☐	Hot flashes	☐	☐	☐	Hips
☐	☐	☐	Ringing in ears	☐	☐	☐	Bursitis	☐	☐	☐	Legs
☐	☐	☐	Depression	☐	☐	☐	Loss of balance	☐	☐	☐	Knees
☐	☐	☐	Stiff neck	☐	☐	☐	Stomach upset	☐	☐	☐	Feet
☐	☐	☐	Neck pain	☐	☐	☐	Cold hands	☐	☐	☐	Sciatica

Has anyone in your family had any of the following diseases? Indicate who the family member(s) underneath the disease.

☐ heart disease ☐ high blood pressure ☐ cancer ☐ stroke ☐ arthritis ☐ diabetes

_____ _____ _____ _____ _____ _____

Drugs you now take: ☐Nerve pills ☐Painkillers ☐Muscle relaxants ☐"Pep" pills
☐Tranquilizers ☐Birth Control ☐Other(s): _____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐

Emergency Contact: Name: _____ Phone #: _____
Medical Doctor: Name: _____ Phone #: _____

Print Name:_____

Signature:_____ Date:_____