

Introduction and History

Date: _____

Name:	Date of birth (Month/Day/Year):
Home Address and Phone Number:	Employer and Work Phone Number:
E-Mail:	Occupation:
Family Medical Doctor:	Referred by (please include person's name): <input type="checkbox"/> Friend/Family <input type="checkbox"/> M.D. / D.C. <input type="checkbox"/> Internet/Social Media
Have you had Chiropractic care before? If so, when and by whom?	Children's Name and Ages:
Spouse's Name and Occupation:	Hobbies:
Please circle sex: Male Female	*If this is a Worker's Comp case please tell us immediately

Why this form is important:

Our office focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible Chiropractic care, we will need to discover any '**stresses**' that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Reason for consulting this office

Wellness / Prevention Care - *I wish to continue my Chiropractic Wellness Care.* Just answer the following questions that apply.

Please describe your current problem, including the effect it has had on your life:

Please describe the character of your pain (check all that apply)

- | | | | | | |
|--|-------------------------------------|---------------------------------------|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp/Stabbing | <input type="checkbox"/> Sharp/Dull | <input type="checkbox"/> Achy | <input type="checkbox"/> Dull | <input type="checkbox"/> Soreness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Throbbing/Gnawing | <input type="checkbox"/> Numbness | <input type="checkbox"/> Shooting | <input type="checkbox"/> Gripping/Constricting | | |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Other: _____ | | | |

Your name: _____

How often are the complaints present?

- Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

When is the pain or symptoms worse:

- When you wake up During the day After work In the evening After eating
 While sleeping

How bad is your pain or ache? Please circle a number (0= no pain, 10 = unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

Since your problem began is the pain : increasing decreasing
 not changing

When did your problem begin: _____ (specific date if possible)

Please draw on the diagram where you feel your symptoms: →

Do you sleep on your:

- Back Stomach Left Side Right Side

Physical Activity at work:

- Sitting more than 50% Light manual labour
 Heavy manual labour

General physical activity:

- No regular exercise program
 Light exercise program Moderate exercise program
 Strenuous exercise program

How would you rate your stress level:

- No Stress Minimal Stress
 Moderate Stress Greatly Stressed

Do you currently smoke? Yes No. If YES please indicate how many packs a day: _____

Number of years: _____

Who else have you seen for this condition: _____

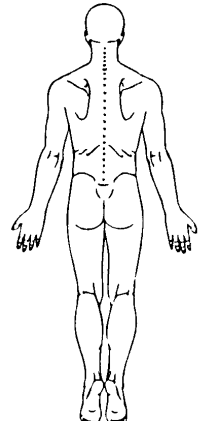
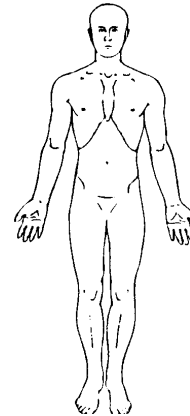
Please describe any falls, auto accidents or major injuries (include Month/Year, Type of accident):

Please describe any and all past surgery: _____

Please list ANY and ALL medication (prescription and over the counter): that you are currently taking:

Please Circle Any That Apply: PERSONAL HISTORY: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other:

Please Circle Any That Apply: FAMILY: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis.
Other: _____



Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem.

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Buzzing/Ringing in Ears | <input type="checkbox"/> Lungs | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Eyes/Vision | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach | <input type="checkbox"/> Leg Pain/Cramps |
| <input type="checkbox"/> Concentration Loss | <input type="checkbox"/> Sinus | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Bladder | <input type="checkbox"/> Numb Feeling |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Liver | <input type="checkbox"/> Feeling of Pins/Needles |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Colon | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Loss Energy | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Kidney | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tired Mornings | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Loss of Taste/Smell | <input type="checkbox"/> Menstrual Pain/Irregularity | <input type="checkbox"/> Urination | <input type="checkbox"/> Fever |

- Do you drink bottled or filtered water: Yes No
- How much water do you drink in a day: _____
- How many servings of fruit and vegetables do you enjoy on a typical day: _____
- Do you belong to a health club or exercises regularly: Yes No

Please list all supplements and vitamins you take:

How would you rate your health:

Yuk I've never felt worse Wow I feel great!
1 2 3 4 5 6 7 8 9 10

How committed are you to improving your health:

Nah, not important I want to be 100% healthy!
1 2 3 4 5 6 7 8 9 10

Do you want to live to be a healthy 85 years old? Yes No

What is 'being healthy' to you (check all that apply)?

- | | |
|---|--|
| <input type="checkbox"/> Not being sick | <input type="checkbox"/> Being symptom free |
| <input type="checkbox"/> Having energy to do what I want, when I want | <input type="checkbox"/> Not needing to take time off work |
| <input type="checkbox"/> To fully enjoy all aspects of life to the fullest extent possible. | |

What is your goal or expectations with Chiropractic care:

Health is significant, but not necessarily serious
– we will do what we can to make each visit stress-free.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Care and Nutritional Care, and I give authority for these procedures to be performed. I have been informed of the Clinic's financial policy and agree that I am responsible for all bills incurred at this office. I have had an opportunity to review the privacy policy and agree to its terms.

Patient/Guardian Name: _____

Patient/Guardian Signature _____ Date: _____