

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/Add
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)

- Sharp/Stabbing Sharp/Dull Achy Dull Soreness Weakness
 Throbbing/Gnawing Numbness Shooting Gripping/Constricting
 Burning Tingling Other: _____

PLEASE TURN OVER →

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:

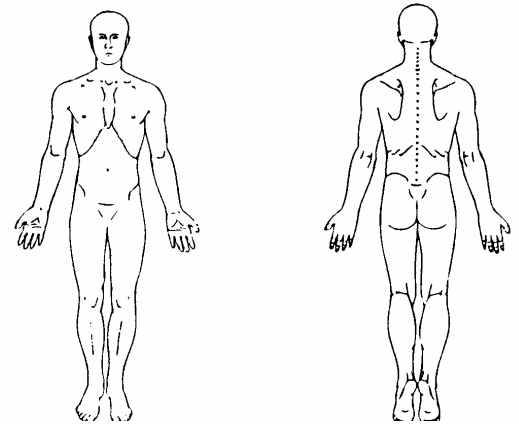
- Back Stomach Left Side Right Side

Physical Activity at work:

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

General physical activity:

- No regular exercise program
 Light exercise program
 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: _____
