PATIENT INFORMATION (please fill this out as completely as possible) DATE:_______________________

First Name:________________________ Initial:______ Last Name:____________________________________

Address:____ Apt #:____________________

City:_______________________________________ Province:__________________________________

Country:____________________________________ Postal Code:_______________________________

Date of Birth (d/m/y):__________________________ Age:_________ Gender:___________________

Occupation:_________________________________ _____________________________# of hours/week

Relationship status:___________________________ # of children:_____________________________

Home #:_____________________________________ Work#:____________________________________

Fax#:_______________________________________ Cell#:_____________________________________

Email Address:____

Family Physician:______________________________ Phone#:__________________________________

Emergency Contact:___________________________ Phone#:__________________________________

Relation:____________________________________

Previous Chiropractor (if any):____

Phone#:__________________________ When was your last visit? (d/m/y):___________________________

Hospitalization: When? _________ For what condition?__________________ For how long: _____________

Surgeries: (type & date): ____

Accidents/Falls/Traumas: (minor/major, type & date): ____

____

Have you broken any bones? If yes, which bones and when: ______________________________________

Have you ever had x-rays taken?_______ If yes, when?____

Which body region?____

Do you have any diagnosed medical conditions? (for example: diabetes, high blood pressure, arthritis, cancer, osteoporosis)____

____

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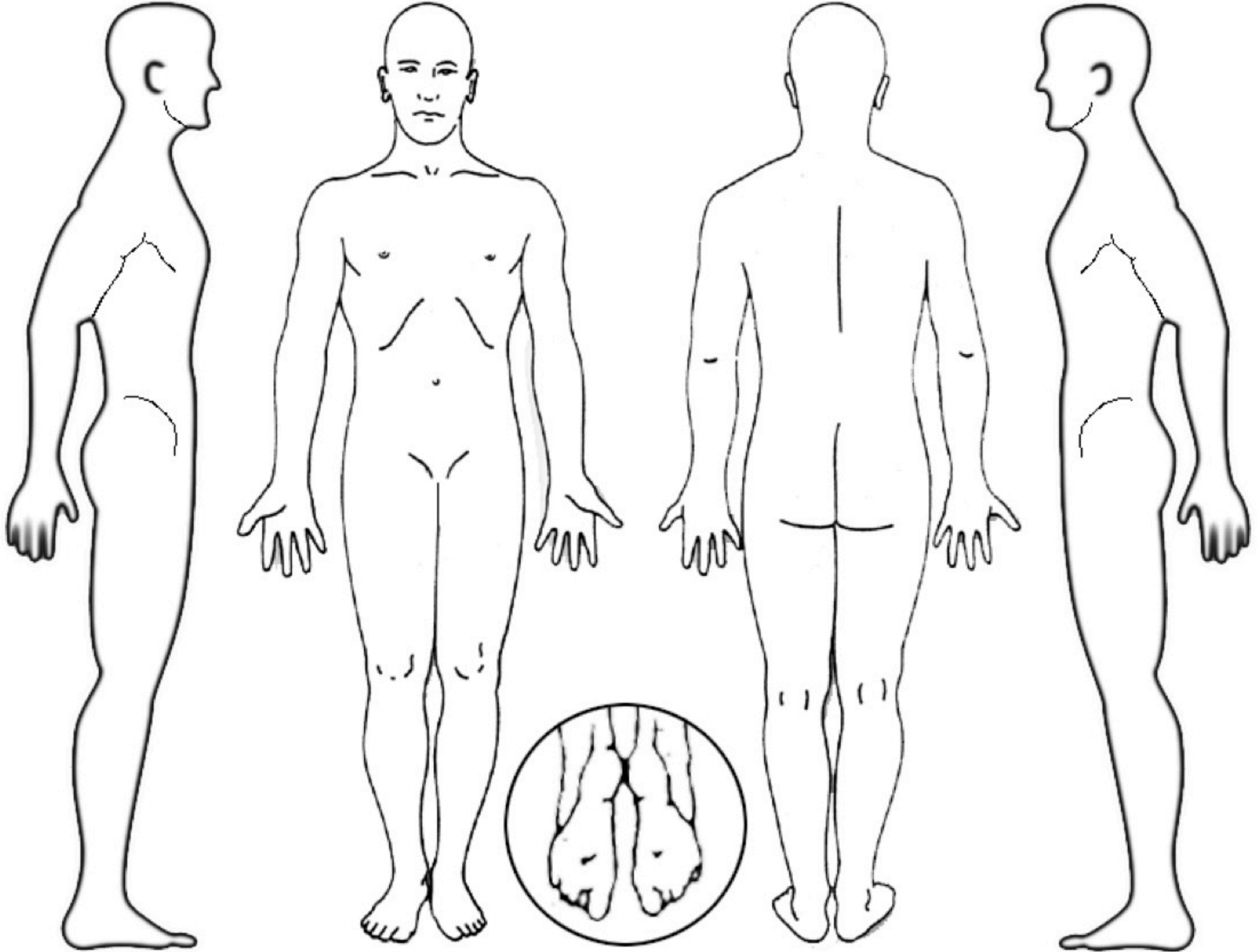
PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES SHOWN BELOW

Pain = x x x x	Stiff & Tight = ////	Numbness= oooo	Dull & Achy= 3 3 3 3
Burning = * * * *	Sharp & Stabbing= v v v v	Pins & Needles= # # # #	Electric Shock= z z z z



How long have you had this complaint?____

Is this complaint getting worse? (if yes, please explain)____

Have you experienced this complaint in the past?____

Please circle which treatment(s) you have sought for this complaint: Were they helpful?_______________________

Medication Physiotherapy Massage Chiropractic Other:______________________________________

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MEDICAL HISTORY

Please answer the following regarding your family history: Have you or anyone in your family (parents, grandparents, siblings, children) been diagnosed with any of the following?: (if yes, please specify whom)

- ❍ Heart Disease ____________________
- ❍ High/Low Blood Pressure ____________________
- ❍ Diabetes ____________________
- ❍ Cancer ____________________
- ❍ HIV/AIDS ____________________
- ❍ Stroke ____________________
- ❍ Blood Clotting Disorder ____________________
- ❍ Anemia ____________________
- ❍ Thyroid Disease ____________________
- ❍ Arthritis ____________________
- ❍ Epilepsy ____________________
- ❍ Multiple Sclerosis ____________________
- ❍ Mental Illness ____________________
- ❍ Other Disease, please specify ____________________

LIFESTYLE

Do you sleep well? Yes / No

What position do you sleep in? (please circle one) Back Stomach Side

Do you consider yourself to be under stress (martital, workplace, domestic, financial)?____________________

____

HABITS

❍ Smoking ______________ pks/day. How long have you been smoking for: _________________months/years

❍ Alcohol _______________ oz/day

❍ Coffee ________________ cups/day

❍ Supplements: ____________________

❍ Medication: ____________________

EXERCISE

❍None ❍ Moderate (2-3 times/week) ❍ Daily: ____# of hours/day ❍____________# of hours/week

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Below are a list of conditions the may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care. Please enter a check mark in the appropriate column for all the signs and symptoms which you may be experiencing **currently (C)** or in the **past (P).** A complete history and understanding of you health status will facilitate care.

General Symptoms

C P

❍ ❍ Headache/Migraine
❍ ❍ Fever
❍ ❍ Chills
❍ ❍ Sweats
❍ ❍ Fainting
❍ ❍ Dizziness
❍ ❍ Convulsions
❍ ❍ Loss of Sleep
❍ ❍ Fatigue
❍ ❍ Nervousness
❍ ❍ Loss of Weight
❍ ❍ Numbness of pain in arms, hands or legs
❍ ❍ Allergies
❍ ❍ Wheezing
❍ ❍ Nerve Pain

Skin

C P

❍ ❍ Rashes
❍ ❍ Itching
❍ ❍ Bruises Easily
❍ ❍ Dryness
❍ ❍ Boils
❍ ❍ Hives (Allergy)
❍ ❍ Hair Loss

Respiratory

C P

❍ ❍ Chronic Cough
❍ ❍ Spitting up Phlegm
❍ ❍ Spitting up Blood
❍ ❍ Chest Pain
❍ ❍ Difficulty Breathing
❍ ❍ Shortness of Breath

Cardiovascular

C P

❍ ❍ Rapid Beating Heart
❍ ❍ High/Low Blood Pressure
❍ ❍ Pain Over Heart
❍ ❍ Stroke
❍ ❍ Swelling of Ankles/Feet
❍ ❍ Hardening of Arteries
❍ ❍ Varicose Veins
❍ ❍ Poor Circulation
❍ ❍ Angina

Genitourinary

C P

❍ ❍ Trouble Urinating
❍ ❍ Blood in Urine
❍ ❍ Pus in Urine
❍ ❍ Kidney Infection
❍ ❍ Bed Wetting
❍ ❍ Prostate Trouble
❍ ❍ Kidney Stones
❍ ❍ Frequent Urination
❍ ❍ Incontinence

Eye, Ear, Nose & Throat

C P

❍ ❍ Failing Vision
❍ ❍ Glasses needed to see: distance, reading
❍ ❍ Crossed Eyes
❍ ❍ Eye pain
❍ ❍ Deafness
❍ ❍ Earache
❍ ❍ Asthma
❍ ❍ Tooth Decay
❍ ❍ Gum Trouble
❍ ❍ Tinnitus (ringing in ears)
❍ ❍ Frequent Colds
❍ ❍ Sinus Infection
❍ ❍ Runny Nose
❍ ❍ Enlarged Glands
❍ ❍ Enlarged Thyroid
❍ ❍ Cold Sores
❍ ❍ Loss of Hearing
❍ ❍ Speech Difficulties
❍ ❍ Jaw/TMJ Pain
❍ ❍ Trouble Swallowing

G.U. for Women

C P

❍ ❍ Hot Flashes
❍ ❍ Irregular Cycle
❍ ❍ Cramps of Back Ache
❍ ❍ Swollen Breasts
❍ ❍ Lumps in Breasts
❍ ❍ Painful Menstruation
❍ ❍ Excessive Flow
❍ ❍ Vaginal Discharge

Muscles & Joints

C P

❍ ❍ Stiff Neck
❍ ❍ Back Ache
❍ ❍ Swollen Joints
❍ ❍ Painful Tail Bone
❍ ❍ Foot Trouble
❍ ❍ Shoulder Pain
❍ ❍ Elbow Pain
❍ ❍ Wrist Pain
❍ ❍ Hand Pain
❍ ❍ Hip Pain
❍ ❍ Knee Pain
❍ ❍ Arthritis

Gastrointestinal

C P

❍ ❍ Poor Appetite
❍ ❍ Indigestion
❍ ❍ Excessive Hunger
❍ ❍ Belching or Gas
❍ ❍ Nausea
❍ ❍ Vomiting (blood?)
❍ ❍ Pain over Stomach
❍ ❍ Constipation
❍ ❍ Diarrhea
❍ ❍ Hemorrhoids (piles)
❍ ❍ Jaundice
❍ ❍ Gall Bladder Trouble
❍ ❍ Intestinal Worms
❍ ❍ Ulcer