WELCOME TO OUR CHIROPRACTIC OFFICE

A complete history is necessary for your doctor to fully understand your condition. Please fill in both sides of this form. If your present condition is the result of a motor vehicle or work related accident, please notify the front desk. (Additional information will be required.) We look forward to serving you.

Name Sex: Male / Female Home Phone

Address City Postal Code

E-mail address Cell Phone

Age Birthdate (month) (day) (year) MSP Personal Health #

Occupation Employer Bus. Phone

Contact Person (in case of emergency) Name Relation to you

Phone (home) (work)

Whom can we thank for referring you? Friend Relative Chiropractor M.D. Name?

Or: Google Online Yellow Pages Sign Yellow Pages Book Other

Have you received treatment by a Chiropractor this calendar year? Yes No Whom?

If not, how long has it been since last treatment? Blood Type

Number of children Are you pregnant at this moment?

Is this an ICBC ❑ or WCB ❑ case? Claim Number

Purpose of this appointment (major complaint)

How long has this condition been present?

What caused this condition? (Describe)

Is this condition: getting worse? remaining constant? coming and going? other

Describe

What activities aggravate your condition?

What relieves the problem?

What are you unable to do because of this problem?

Have you received other forms of treatment for your condition? (medical, physiotherapy, etc.) (Describe)

Have X-rays been taken? When? Where?

What part of your body was X-rayed?

Have you been treated by a medical physician in the past year for any health problems? (Describe)

Family physician's name

Are you taking any medication, drugs, or supplements? (Describe)

Please Complete Reverse Side

Height: Feet Inches Weight: lbs.

Have you had any surgery, operations? (Describe/give dates)

Have you had any serious illnesses? (Describe/give dates)

Have you had any accidents, broken bones, sporting injuries, etc.? (Describe/give dates)

Any history of environmental toxicity? (Describe/give dates)

GENERAL SYMPTOM SURVEY — *Please check those that you experience on a regular basis:*

_____ Allergy	_____ Spinal curvatures	_____ Nosebleeds	_____ Pleurisy
_____ Dizziness	_____ Poor posture	_____ Sinus problems	_____ Varicose veins
_____ Fatigue	_____ Constipation	_____ High blood pressure	_____ Frequent urination
_____ Headaches	_____ Diarrhea	_____ Low blood pressure	_____ Kidney infection or stone
_____ Loss of sleep	_____ Colitis	_____ Pain over heart	_____ Prostate trouble
_____ Tire easily	_____ Bedwetting	_____ Poor circulation	_____ Menstrual cramps or backache
_____ Ulcers	_____ Nausea	_____ Rapid heart beat	_____ Excessive menstrual flow
_____ Indigestion	_____ Asthma	_____ Slow heart beat	_____ Hot flashes
_____ Nervousness / worry	_____ Colds	_____ Hernia	_____ Irregular cycle
_____ Depression	_____ Cough	_____ HIV+ &/or AIDS-related	_____ Lumps in breast
_____ Arthritis	_____ Deafness	symptoms	_____ Swelling of ankles
_____ Bursitis	_____ Ringing in ears	_____ Alcoholism	_____ Epilepsy
_____ Foot trouble	_____ Visual symptoms	_____ Anemia	_____ Diabetes
_____ Low back pain	_____ Eye pain	_____ Stroke	_____ Hypoglycemia
_____ Neck pain or stiffness	_____ Bruise easily	_____ Chest pain	_____ Hemorrhoids
_____ Sciatica	_____ Hay fever	_____ Difficulty breathing	_____ Polio

Tingling or numbness: Shoulders Arms Elbows Hands Hips Legs Knees Feet

Family history of: TB Diabetes Heart conditions Cancer Other

Lifestyle Choices:	Heavy	Moderate	Light	None		Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____	Exercise	_____	_____	_____	_____
Coffee/Tea/Soft Drinks	_____	_____	_____	_____	Sleep	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	Appetite	_____	_____	_____	_____
Prescription Drugs	_____	_____	_____	_____	Stress	_____	_____	_____	_____
Non-prescription Drugs	_____	_____	_____	_____	Leisure	_____	_____	_____	_____

Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

Additional information about your health and/or significant stresses in your life (past and present):

Please indicate the type(s) of chiropractic care you are interested in receiving:

❑ Relief of pain and other symptoms ❑ Rehabilitation of injury ❑ On-going prevention and wellness care

Services rendered in this office are the responsibility of the patient should medical services plan or other third party plans fail to pay all or part of the amount due. Payment is due at time of service.

Signature Date