

**PERSONAL HISTORY**

DATE	#
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Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F  
Email \_\_\_\_\_ day/month/year  
Business / Employer \_\_\_\_\_ Type of Work \_\_\_\_\_  
Business Phone \_\_\_\_\_ **Circle One:**  
Name & Relationship of Emergency Contact \_\_\_\_\_ Married  Single  Widowed  Divorced  Separated  Other  
Phone # of Emergency Contact \_\_\_\_\_ # of Children \_\_\_\_\_  
Do you have Extended Health Benefits?  Y  N Insurance Company \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

Who may we thank for referring you to this office \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Reason for seeking chiropractic care today? \_\_\_\_\_

Other Doctors seen for this condition: Yes No Who? \_\_\_\_\_

Types of treatment: \_\_\_\_\_ Results: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_ Has this condition occurred before?  Yes  No

Is condition:  Job Related  Auto related  Home Injury  Fall  Other \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

What aggravates your condition?  Sitting  Standing  Bending  Lifting  Walking  
 Lying Down  Cold  Dampness  Other \_\_\_\_\_

What relieves your condition?  Bed rest  Ice  Heat  Massage  Medication  
 Other \_\_\_\_\_

Is it getting:  Worse  Constant  Comes /Goes  Better

Character of Pain:  Sharp  Dull  Ache  Pins & Needles  Burning

Constant  Comes & Goes  Radiating  Numb

Please circle the severity of the pain at its worst Least -- 1 2 3 4 5 6 7 8 9 10 -- Worst

Does this cause you to be...

- Moody
- Irritable
- Interrupted Sleep
- Restricted Daily Activity

Does this affect your work...

- Decision Making
- Poor Attitude
- Decreased Productivity
- Exhausted at End of Day
- Unable to Work Long Hours

Does this affect your life...

- Lose patience with spouse or child
- Restricted household duties
- Hinder ability to exercise
- Hinder ability to do hobbies

If you don't get this problem corrected, do you think it will get worse over the next 5 years?  Yes  No

Drugs you now take:  Nerve Pills  Pain Killers / Muscle Relaxers  Blood Pressure  Cholesterol  
 Insulin  Birth Control  Anti-depressants  Other \_\_\_\_\_

Are you being treated for any other medical conditions? \_\_\_\_\_

Have you had any X-rays taken in the last 6 months?  Yes  No If yes, where? \_\_\_\_\_

**PAST HEALTH HISTORY**

Please check or describe:

Major Surgery / Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  Back Surgery  
 Broken Bones  Hysterectomy  Other: \_\_\_\_\_

Previous: Childhood Traumas  \_\_\_\_\_ Sports Injuries  \_\_\_\_\_

Motor Vehicle Accident  \_\_\_\_\_ Work Injuries  \_\_\_\_\_

Hospitalizations (other than above): \_\_\_\_\_

Previous Chiropractic Care:  None  Yes, Doctors name and approx. date of last visit: \_\_\_\_\_

**FAMILY HEALTH HISTORY**

Does any member of your family suffer from the same condition?  No  Yes Whom? \_\_\_\_\_

Have your children ever had a spinal checkup?  No  Yes

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**Check any of the following Diseases you have had:**

- Pneumonia
- Mumps
- Influenza
- Rheumatic Fever
- Small Pox
- Pleurisy
- Polio
- Chicken Pox
- Arthritis
- Tuberculosis
- Diabetes
- Epilepsy
- Whooping Cough
- Cancer
- Mental Disorder
- Anemia
- Heart Disease
- Lumbago
- Measles
- Thyroid
- Eczema

**Check any of the following you have had in the past six months:**

**Musculo-Skeletal**

- Low Back Pain
- Pain Between Shoulders
- Headaches
- Neck Pain
- Black/Bloody Stool
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

**Nervous System**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

**C-V-R**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems / Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

**General**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Weight Trouble

**EENT**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

**Gastro-Intestinal**

- Poor / Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Colitis
- Liver Problems
- Gall Bladder Problems
- Heartburn / Gas / Bloating
- Abdominal Cramps

**Male/Female**

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain / Infections
- Breast Pain / Lumps
- Prostate / Sexual Dysfunction

**Genito-Urinary**

- Bladder Trouble
- Painful / Excessive Urination
- Discoloured Urine

**Females Only**

When was your last period? \_\_\_\_\_

Are you pregnant?

- Yes
- No
- Not Sure

**Intake**

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

**Personal Satisfaction with Diet**

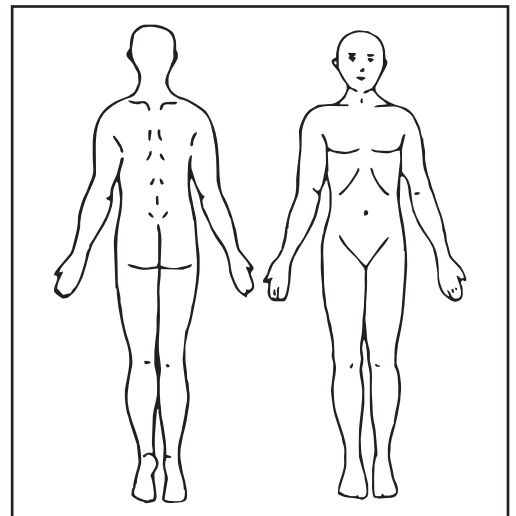
- Highly Satisfied
- Dissatisfied
- Highly Dissatisfied

**Do you have a regular exercise program?**

- Yes
- No

**Lifestyle Stress Levels**

- High
- Moderate
- Very Little



Please outline on the diagram the area of your discomfort and any radiation of pain.