TOTAL CHIROPRACTIC
92 Elm Street, Brantford, ON N3R 4V2
Ph: 519 756- 8171 Fax: 519 756-0731

Patient # _____

PATIENT INFORMATION SHEET

Name: _____ Date: _____

Address: _____ City: _____

Email:_____

Province: _____ Postal Code: _____ Medical Doctor: _____

Birth Date: Day _____ Mo. _____ Yr. _____ Age: _____ Sex: ☐ M ☐ F

Home Phone: _____ Bus Phone: _____ Mobile: _____

Height: _____ Weight: _____ No. of Children: _____ Ages: _____

Business/Employer: _____ Type of Work: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Extended Health Coverage: ☐ Chiropractic ☐ Massage Therapy ☐ Naturopathic ☐ Orthotics

Company Name: _____ Yearly Coverage: _____

How did you hear about our clinic? _____

Major Complaint: _____

Other Doctors seen for this condition: _____

When? _____ When did this condition begin? _____

Are there others in your family with the same condition? _____

If disabled from work, please give dates: _____

☐ Job Related ☐ Auto Related Date of Accident/Injury: _____

Medication you now take: ☐ Nerve Pills ☐ Blood Pressure ☐ Pain Killers/Muscle Relaxants
☐ Insulin ☐ Aspirin/Similar ☐ Supplements

Other: _____

_____

PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations: ☐ Appendix ☐ Gallbladder ☐ Tonsils ☐ Heart ☐ Back
☐ Neck ☐ Leg ☐ Other _____

Major Accidents or Falls: _____

_____

Hospitalization (other than above): _____

_____

Have you been treated for a health condition in the past year? ☐ Yes ☐ No

If yes, please explain: _____

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 DISEASE YOU HAVE HAD:

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

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST SIX MONTHS

MUSCULO-SKELETAL SYSTEM

☐ Low Back Pain
☐ Neck Pain
☐ Arm Pain
☐ Leg Pain
☐ Pain Between Shoulders
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficult Chewing/Clicking Jaw

FEMALES ONLY

When was your last period? _____
Are you pregnant? ☐Yes ☐ No☐Not Sure
☐ Menstrual Irregularity
☐ Menstrual Cramping
☐ Vaginal Pain/Infections
☐ Breast Pain/Lumps

NERVOUS SYSTEM

☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling extremities
☐ Stress

GENERAL

☐ Fatigue
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches

CARDIOVASCULAR SYSTEM

☐ Chest Pain
☐ Shortness of Breath
☐ Blood Pressure Problems
☐ Heart Problems
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke

Please outline on the diagram
the area (s) of discomfort.