

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 Pain Between Shoulders
- Neck Pain Joint Pain/Stiffness
- Arm Pain Walking Problems
- Leg Pain Difficult Chewing/Clicking Jaw

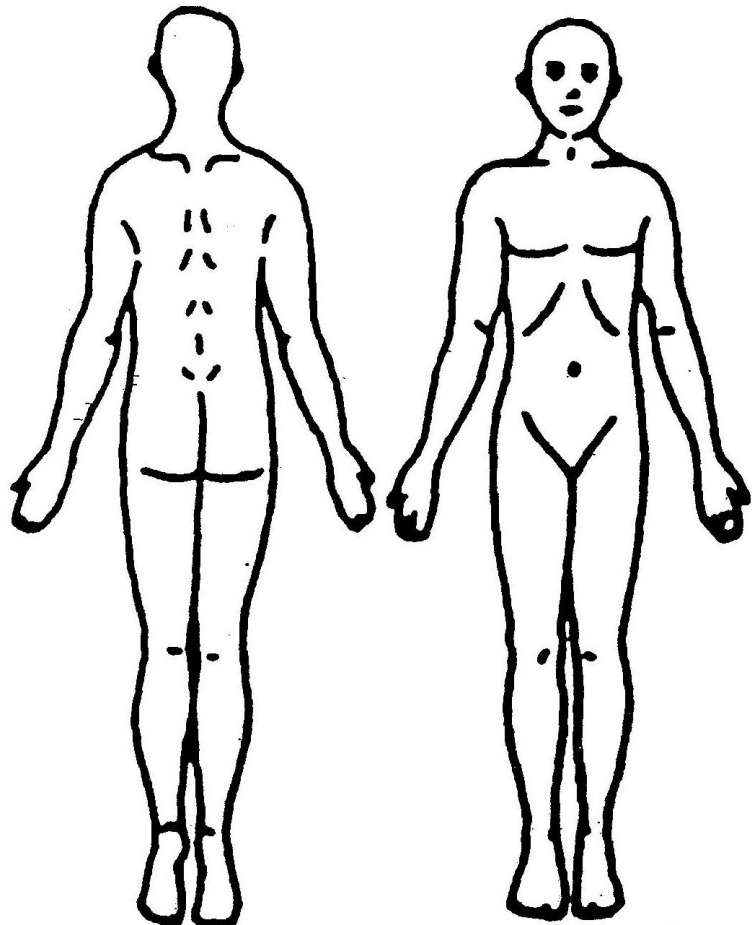
FEMALES ONLY

- 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

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



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