

DATE

DIAGNOSIS:

PERSONAL HISTORY

Name, Address, City, Prov., Home Phone, Employer, Type Of Work, Health Card #, Social Insurance #, Birth Date, Age, Sex, Referred To This Office By, Names & Ages Of Children, Check One: Married, Single, Widowed, Divorced, Separated, Name & Number of Emergency Contact, Previous Chiropractic Care, What Type Of Care Are You Interested In?

CURRENT HEALTH CONDITION

Purpose Of This Appointment, Other Doctors Seen For This Condition, Type Of Treatment, Results, When Did This Condition Begin?, Has This Condition Occurred Before?, Is Condition: Job Related, Auto Accident, Home Injury, Fall, Other, Date Of Accident, Time Of Accident, Have You Made A Report Of Your Accident To Your Employer?, Drugs You Now Take, Do You Wear A Shoe Lift?, Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?

PAST HEALTH HISTORY

Anything Unusual About Your Birth (i.e. Breech, Forceps, C-Section), Any Major Or Recurrent Childhood Illnesses Or Falls (i.e. Recurrent Ear Infections, Pneumonia, Dropped As A Child), Major Surgery/Operations: Appendectomy, Tonsillectomy, Gall Bladder, Hernia, Back Surgery, Broken Bones, Other, Any Car Accidents Or Falls, Hospitalization (Other Than Above):

Below are a list of conditions 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 YOU HAVE HAD IN THE PAST 6 MONTHS

MUSCULO-SKELETAL CODE

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

NERVOUS SYSTEM CODE

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

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting

- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stools
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discoloured Urine

C-V-R CODE

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

EENT CODE

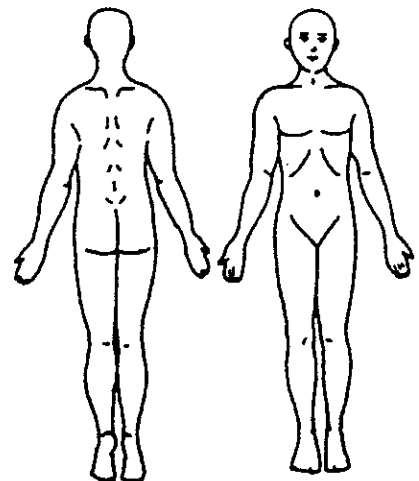
- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____
 Are you pregnant?
 Yes No Not Sure



Please outline on the diagram the area of your discomfort.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- Cancer
- Heart Disease
- Thyroid
- Diabetes
- Arthritis

Have you been tested HIV positive? Yes No _____

FAMILY HISTORY

Is there any family history of arthritis, heart disease, cancer or diabetes? Yes No If yes, please explain

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child