ACQUAINTANCE INFORMATION

THE DATA ON THIS CONFIDENTIAL FORM IS ESSENTIAL IF WE ARE TO RENDER THE BEST PROFESSIONAL CARE. WE APPRECIATE YOUR CO-OPERATION IN FILLING IT OUT SO THAT WE WILL HAVE ACCURATE RECORDS. PLEASE PRINT – THANK YOU.

PERSONAL INFORMATION

Date				
PATIENT'S LAST NAME	FIRST NAME			HOME PHONE
HOME ADDRESS	CITY/TOWN			POSTAL CODE
DATE OF BIRTH	DAY/MONTH/YEAR	M or F	OCCUPATION	BUSINESS PHONE
EMPLOYER		BUSINESS ADDRESS		
MARITAL STATUS	NAME OF SPOUSE		OCCUPATION	BUSINESS PHONE
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?			BY WHOM WERE YOU REFERRED?	
NUMBER AND AGES OF CHILDREN				

PROVINCIAL HEALTH CARE INSURANCE PLAN

ALBERTA HEALTH CARE NUMBER

CHIROPRACTIC HEALTH INFORMATION

(PLEASE CIRCLE YOUR ANSWER TO EACH QUESTION, IF YES, EXPLAIN)

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? NO YES
WHEN WAS YOUR LAST VISIT? ______________________________
NAME OF CHIROPRACTOR ____________________________ TOWN/CITY ____________________________
WHY DID YOU SEEK CARE? ____________________________ X-RAYS TAKEN? NO YES

****

MAJOR COMPLAINT

WHERE IS YOUR MAJOR COMPLAINT? ____
DATE OF ONSET: (D) _______/(M) ________ (Y) ________
ONSET WAS: SUDDEN / GRADUAL / ASSOCIATED WITH AN EVENT
PLEASE EXPLAIN ____
HOW LONG HAVE YOU HAD THIS CONDITION? _______ MINUTES / HOURS / DAYS / MONTHS / YEARS
HAS THE PROBLEM BEEN: CONSTANT / INTERMITTENT / OCCASIONAL / CYCLICAL

INDICATE THE PRESENT INTENSITY OF THE PAIN BY CIRCLING THE APPROPRIATE NUMBER:
(MILD) 1 2 3 4 5 6 7 8 9 10 (VERY INTENSE)

WHAT DOES THE PAIN FEEL LIKE? DULL / ACHING / BURNING / THROBBING / SHARP
OTHER: ____
WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? ____
WHAT MAKES IT FEEL BETTER? ____
DOES THIS LIMIT YOUR DAILY ACTIVITES? YES NO. IF SO, WHICH ACTIVITIES ARE AFFECTED?
____
HAVE YOU HAD THIS OR A SIMILAR CONDITION IN THE PAST? YES NO. WHEN? ________________

SECONDARY COMPLAINT (IF A. . LICABLE)

WHERE IS YOUR SECONDARY COMPLAINT? ______________________

DATE OF ONSET: (D) _______/(M) ________ (Y) ________

INDICATE THE PRESENT INTENSITY OF THE PAIN BY CIRLCING THE APPROPRIATE NUMBER:

(MILD) 1 2 3 4 5 6 7 8 9 10 (VERY INTENSE)

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? ______________________

WHAT MAKES IT FEEL BETTER? ______________________

HEALTH HISTORY

PLEASE LIST ANY SURGICAL OPERATIONS: ______________________

AND THE YEARS THEY WERE PERFORMED: ______________________

NAME OF FAMILY DOCTOR: ______________________

ARE YOU CURRENTLY TAKING:

BIRTH CONTROL PILLS	INSULIN	MUSCLE RELAXANTS	NERVE PILLS
PAIN KILLERS	VITAMINS	TRANQUILIZERS	PEP PILLS

OTHER MEDICATIONS: ______________________

ARE YOU PRESENTLY UNDER THE CARE OF A PHYSIOTHERAPIST?: NO YES IF YES, WHO? __________

ARE YOU PRESENTLY SEEING A NATUROPATH OR HOMEOPATHIC DOCTOR? NO YES WHO? ________

DO YOU SMOKE? NO YES IF SO, HOW MANY PER DAY? ________ FOR HOW LONG? ________

HOW DO YOU SLEEP? ON BACK ON SIDE ON STOMACH A COMBINATION

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? NO YES DATE(S): ______________

DESCRIBE: ______________________

HAVE YOU HAD ANY OTHER PERSONAL INJURY? PAST YEAR PAST 5 YEARS OVER 5 YEARS

PLEASE DESCRIBE: ______________________

INTERESTS OR HOBBIES: ______________________

Below is 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 effect your overall diagnosis, treatment plan and possibility of being accepted for care. Please indicate if you've had any of the following in your lifetime by checking the appropriate box:

☐ Appendicitis	☐ Malaria	☐ Chicken Pox	☐ Asthma
☐ Scarlet Fever	☐ Tuberculosis	☐ Diabetes	☐ Polio
☐ Diptheria	☐ Whooping Cough	☐ Cancer	☐ Arthritis
☐ Typhoid Fever	☐ Anemia	☐ Heart Disease	☐ Epilepsy
☐ Pneumonia	☐ Measles	☐ Goiter	☐ Psychological Disorders
☐ Rheumatic Fever	☐ Mumps	☐ Influenza	☐ Small Pox

IN YOUR FAMILY, IS THERE A HISTORY OF SERIOUS DISEASE? EXPLAIN ______________________

____

Below is 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 effect your overall Diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING YOU **HAVE** OR **HAVE HAD** IN THE PAST 6 MONTHS:

MUSCLO-SKELETAL CODE

☐Low Back Pain
☐Pain Between Shoulders
☐Neck Pain
☐Arm Pain
☐Difficult Chewing/ Clicking Jaw

NERVOUS SYSTEM CODE

☐Numbness
☐Paralysis
☐Dizziness
☐Forgetfulness
☐Confusion
☐Depression
☐Fainting
☐Convulsions
☐Cold/Tingling Extremities

GENERAL CODE

☐Allergies
☐Loss of Sleep
☐Fever
☐Headaches

GASTRO-INTESTINAL CODE

☐Poor/Excessive Appetite
☐Excessive Thirst
☐Frequent Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Hemorrhoids
☐Liver Trouble
☐Gall Bladder Problems
☐Weight Changes
☐Abdominal Cramps
☐Gas/Bloating After Meals
☐Heartburn
☐Black/Bloody Stool
☐Colitis

GENITO-URINARY CODE

☐Bladder Trouble
☐Painful/Excessive Urination
☐Discolored Urine

C-V-R CODE

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

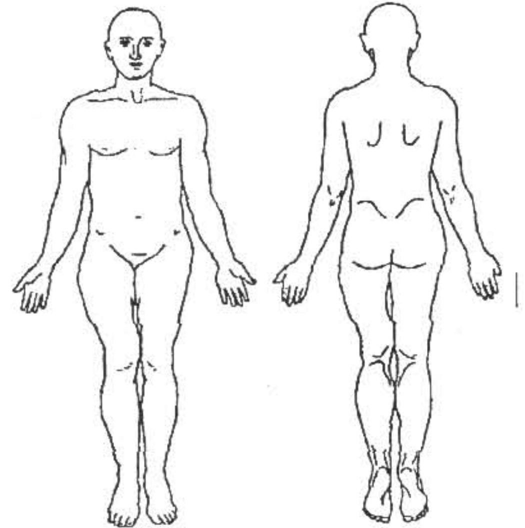
EENT CODE

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

MALE / FEMAL CODE

☐Menstrual Irregularity
☐Menstrual Cramping
☐Vaginal Pain/Infections
☐Breast Pain/Lumps
☐Prostate/Sexual Dysfunction
☐Genital Herpes

Please outline in the diagram the area of your discomfort.



FEMALES ONLY:

When was your last period? __________

Are you pregnant? ☐Yes ☐No ☐Maybe