Confidential Case History

Date:_____

Please complete the following questionnaire. Your answers will help us to determine if Chiropractic can help you.
Thank You!

Name: _____ Date of Birth: _____ Age: _____ Sex: ☐ ☐
Address: _____ City: _____Province: _____ Postal Code: _____
Home Telephone #: _____ Work #: _____ Cell #: _____
Email: _____*by adding your email address you consent to receiving electronic reminder notices*
Marital Status: ☐Single ☐ Married ☐ Widowed ☐ Divorced
Number of Children: _____ Children's Names (Ages): _____
Alberta Healthcare #:_____
Occupation: _____ Name of Business: _____
Emergency Contact Name and Number: _____
Referred By: _____ Specific Doctor? _____
Claim Will Be Made Against:

1. Recent motor vehicle claim? ☐ Yes ☐ No
2. Work related injury/accident (WCB)? ☐Yes ☐ No WCB #: _____

HEALTH INFORMATION:
Reason for attending office: _____
_____
Location of Pain: _____
When did you notice it? _____ How often does it occur? _____
Does it radiate? ☐ Yes ☐ No If yes, where? _____
What relieves it? _____
What aggravates it? _____
Describe how it interferes with your life, work, or hobbies? _____
_____
When have you had this or similar conditions in the past? _____
Is condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes
Have you had previous Chiropractic care? ☐ Yes ☐ No
Where? _____ When? _____ Were x-rays taken? ☐es ☐No
Why? _____
Other treatments tried: _____
How long has it been since you really felt good? _____

PAST HEALTH HISTORY:
Please check if you presently have or have had any of the following conditions in the past:

☐ Blurring of Vision	☐ Bronchitis	☐ Diarrhea	☐ Insomnia
☐ Stroke	☐ Asthma	☐ Stomach Ulcer	☐ Respiratory Condition
☐ Dizziness	☐ Tendonitis	☐ Heart Burn	☐ Urinary Frequency
☐ Depression	☐ Chest Pains	☐ Headaches	☐ Lower Back Pain
☐ Heart Disease	☐ Diabetes	☐ Allergies	☐ High Blood Pressure
☐ Aneurysm	☐ Hiatus Hernia	☐ Sinusitis	☐ Menstrual Problems
☐ Varicose Veins	☐ Constipation	☐ Ringing in ears	☐ Numbness or Tingling
☐ Cancer	☐ Arthritis	☐ Osteoporosis	in Arms or Legs

Any family health conditions: ☐ Yes ☐ No Please list:_____
Other health problems? _____
_____
List surgical operations or hospitalizations and years they occurred: _____
_____
Pregnancies? _____
List of medications or vitamins you now take: _____
_____

Rate your diet:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your sleep habits:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your exercise:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your mental state:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent

List and describe any auto accidents or other accidents/injuries: _____
_____
_____
List and describe any childhood injuries/accidents/hospitalizations/illnesses: _____
_____
Anything else you feel we should know about? _____
_____

Draw in your face.
Show area(s) of pain or unusual feeling.
Mark the areas on this body where you feel the
described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.

Numbness
● ●
● ●
● ●

Pins & Needles
○ ○
○ ○
○ ○

Burning
X X
X X
X X

Aching
* *
* *
* *

Stabbing
/ /
/ /
/ /