

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? Yes 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:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Blurring of Vision | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Respiratory Condition |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Urinary Frequency |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Hiatus Hernia | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Constipation | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Numbness or Tingling |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> 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.

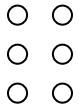
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.

Mark areas of radiation. Include all affected areas.

Numbness



Pins & Needles



Burning



Aching



Stabbing

