

CAUSES OF SPINAL / NERVE PROBLEMS (SUBLUXATION)

A. EMOTIONAL STRESS:

High med low
 Business 3 2 1
 Social 3 2 1
 Family 3 2 1

A _____
 Total

B. CHEMICAL STRESS:

- Environment
- Smoker - Amount?
- Second-hand Smoke
- Poor Diet
-
- Excessive Sugar
- Artificial Sweeteners
- Prescription Drugs / Specify

Over-The-Counter Drugs /
 (Example: Tylenol; Advil)

B _____
 Total

C. PHYSICAL STRESS:

- Birth Traumas (as a mother or child)
- Slips/Falls
- Car Accidents
- Knocked unconscious
- Sports Injuries
- Poor Posture
- Sitting on your wallet
- Sleeping Position - Stomach
- Extensive Computer Work
- Carrying Heavy Purse/Bookbag/Child
- Repetitive Lifting / Bending
- Continuous Hours Sitting/Standing
- Bone Fracture/Surgery

C _____
 Total

TOTAL STRESS: _____
 (add A, B and C)

Are you currently on a program of

a) vitamins b) minerals c) herbs d) diet e) exercise f) others?

What is your estimation of your present general health?	Good	Fair	Poor
Are you frequently ill?	Yes		No
Do you often feel exhausted?	Yes		No
Do you have trouble sleeping?	Yes		No
Do you have any allergies (to food, cat's fur, dust, etc.)?	Yes		No
Do you consider yourself to be a nervous person?	Yes		No
Are you worried about receiving chiropractic care?	Yes		No

Please inform your doctor if your health changes in any way.

NEW PATIENT FORM

The information you provide is for the confidential use of this office and will only be released with your written consent or if your treatment is covered under Worker's Compensation.

Patient Name: _____ Date: _____

Home Address: _____ Phone#: _____

City: _____ Postal Code: _____

Occupation: _____ Bus. Phone# _____

Email: _____ (For Appointment Reminders)

Birth Date: _____ Age: _____ Sex: M F Status: S M CL

Name of Partner: _____ Number of Children: _____

AHC# _____

Do you have other insurance coverage?: Y__ N__

Motor Vehicle Accident: Y__ N__ Worker's Compensation Board: Y__ N__

Referred By: _____

Emergency Contact: _____ Phone #: _____

Previous Chiropractic Doctor: _____ Address: _____

Medical Doctor: _____ Address: _____

REASON FOR CONSULTING THIS CLINIC:

Why chiropractic? People go to chiropractors for a variety of reasons. Some are interested in getting to the cause of their health problems and promoting more complete healing. Muscle and soft tissue injuries can remain even without pain, so the goal is to strengthen and stabilize the body to avoid a relapse (corrective care). More and more people, however, interested in improving their overall health and wellness. They see chiropractors for preventive checkups and programs on how to optimize their health (wellness/maintenance care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible. Check more than one box if applicable.

Pain Relief Only Corrective Care (avoids a relapse)

Maintenance / Wellness Care
 (A proactive approach to health that helps you continue feeling well)

What is your major concern? _____

How long have you had this condition(s)? _____

Have you had this similar condition in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Y__ N__ Constant __ Comes and Goes__

Is this condition interfering with your work __ Sleep__ Daily Routine__ Other? _____

How long has it been since you really felt good? _____

Others who have treated this condition: _____

In the past 5 years, have x-rays been taken? No Yes
 If yes, where? _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. 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

- Numbness
- Headaches
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

- Recent Surgery
- Wear Pacemaker

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discoloured Urine
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

C-V-D CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Heart Problems
- Lung Problems
- Varicose Veins
- Ankle Swelling
- Stroke

EENT CODE

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

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

I have no discomfort, I am here for a check-up and Wellness care.

I do have discomfort in the following areas:

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

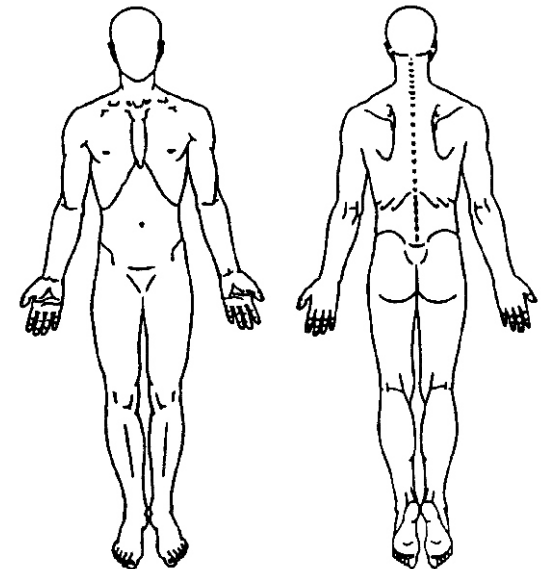
Numbness ● ● ●

Pins & Needles 0 0 0

Burning XXX

Aching AAA

Stabbing / / /



Please mark on the line below where you would describe your pain level today.

