Name: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M/F Height \_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alberta Health Care Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your condition related to work? No Yes

If yes, has your employer been notified? No Yes

Is your condition related to a motor vehicle accident? No Yes

Is yes, what date did the accident occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications you are taking and for what conditions (prescriptions, vitamins, herbal supports, BCP, aspirin, etc):

Personal Medical History - Please list any past or present medical conditions/illnesses (cancer, diabetes, high blood pressure, stroke, heart issues, etc):

Date of Last Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a chance that you are pregnant? No Yes

Have you had x-rays taken? No Yes If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? No Yes If yes, please specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever:** | **No** | **Yes** | **Briefly Explain** |
| Broken bones? |  |  |  |
| Been hospitalized? |  |  |  |
| Been in an auto accident? |  |  |  |
| Been struck unconscious? |  |  |  |
| Had surgery? |  |  |  |

|  |  |  |
| --- | --- | --- |
| Do you experience pain every day? | No | Yes |
| Do your symptoms interfere with daily life? | No | Yes |
| Does pain wake you up at night? | No | Yes |
| Are your symptoms worse during certain times of the day? | No | Yes |
| Do changes in weather affect your symptoms? | No | Yes |
| Do you wear orthotics? | No | Yes |
| What activities aggravate your symptoms? Please list: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Habits** | **None** | **Light** | **Moderate** | **Heavy** |
| Alcohol |  |  |  |  |
| Coffee |  |  |  |  |
| Tobacco |  |  |  |  |
| Drugs |  |  |  |  |
| Exercise |  |  |  |  |
| Sleep |  |  |  |  |
| Appetite |  |  |  |  |
| Soft drinks |  |  |  |  |
| Water |  |  |  |  |
| Salty foods |  |  |  |  |
| Sugary foods |  |  |  |  |
| Artificial sweeteners |  |  |  |  |

Family Medical History – Please list any past or present medical conditions/illnesses (cancer, diabetes, high blood pressure, etc) in your family (Grandparents, Parents, Siblings):

Have you had previous chiropractic care? No Yes If yes: Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit: \_\_\_\_\_\_\_\_\_\_\_

Emergency Contact # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient (or parent/guardian) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_