PERSONAL HISTORY

Name: ____ Male / Female
First Last

Birthdate (mm/dd/yr): ______________ Please circle one: Single / Married / Common Law / Separated / Divorced / Widowed

Home Address: ____
Street City Province Postal Code

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ *Email: ______________________
*By providing us with your email address you are expressing consent to receive emails from us such as; appointment reminders, account statements and newsletters.

Employer / Occupation ______________________ Emergency contact: ______________________

Alberta Health Care Number: ______________ Name of person legally responsible: ______________

PAYMENT IS EXPECTED AT TIME OF VISIT
Name of person responsible for payment: ______________________________

Who may we thank for the referral? ______________________________

PRESENT COMPLAINTS

List: ____

Previous Chiropractor: ______________________ Date of last visit: ______________________

Previous treatment for this condition: ______________________________

Have you been treated by a physician in the last year for any health condition? Yes / No

Describe: ____

Physician name & contact: ______________________ Is this a Workers Compensation claim? Yes / No

HABITS & VITAMINS

Sleeping problems: None / Getting up / Falling asleep / Staying asleep

Explain: ____

Vitamins: ____

Vacations (How often?) ______________________ Exercise (How often?) ______________________

Tea, Coffee (How much?) ______________________ Alcohol (How much?) ______________________

Tabacco (How much?) ______________________ Diet (Allergies / Intolerances) ______________________

Current Health Conditions: ______________________________

What do you hope to enjoy more or do better with improved health? ______________________
____

Remarks & Additional information: ______________________________

Please indicate for each of the questions below your experience by checking the appropriate box:

	PRESENTLY	PREVIOUSLY
MUSCULO-SKELETAL SYSTEM		
Low Back Problems	o	o
Pain Between Shoulders	o	o
Neck Problems	o	o
Arm Problems	o	o
Leg Problems	o	o
Swollen Joints	o	o
Painful Joints	o	o
Stiff Joints	o	o
Sore Muscles	o	o
Weak Muscles	o	o
Ruptures	o	o
Broken Bones	o	o
FEMALE CODE	o	o
Vaginal Discharge	o	o
Vaginal Bleeding	o	o
Vaginal Pain	o	o
Breast Pain	o	o
Lumps on Breast	o	o
Pregnant	o	o
Date of Last Period	____________________	
GASTRO-INTESTINAL SYSTEM		
Poor Appetite	o	o
Excessive Hunger	o	o
Difficult Chewing	o	o
Excessive Thirst	o	o
Nausea	o	o
Vomiting Food	o	o
Vomiting Blood	o	o
Abdominal Pain	o	o
Diarrhea	o	o
Constipation	o	o
Black Stool	o	o
Bloody Stool	o	o
Hemorrhoids	o	o
Liver Trouble	o	o
Gall Bladder Problems	o	o
Weight Trouble	o	o

PLEASE CHECK IF YOU HAVE HAD THE FOLLOWING:

o Stroke o Tuberculosis o S.T.D.

o Cancer o Alcoholism o Hypoglycemia

o Diabetes o Epilepsy o Rheumatic Fever

o Arthritis o Allergies o Heart Disease

	PRESENTLY	PREVIOUSLY
NERVOUS SYSTEM		
Numbness	o	o
Loss of Feeling	o	o
Paralysis	o	o
Dizziness	o	o
Fainting	o	o
Headaches	o	o
Muscle Jerking	o	o
Convulsions	o	o
Forgetfulness	o	o
Confusion	o	o
Depression	o	o
CARDIO-VASCULAR-RESPIRATORY		
Blood Pressure	o	o
Problems	o	o
Pain over Heart	o	o
Persistent Cough	o	o
Coughing Phlegm	o	o
Rapid Heartbeat	o	o
Vision Problems	o	o
Heart Problems	o	o
Lung Problems	o	o
Varicose Veins	o	o
EYE, EAR, NOSE,THROAT		
Eye Strain	o	o
Eye Inflammation	o	o
Vision Problems	o	o
Ear Pain	o	o
Ear Noises	o	o
Hearing Loss	o	o
Ear Discharge	o	o
Difficult Breathing	o	o
Sore Gums	o	o
Dental Problems	o	o
Sore Mouth		o
Sore Throat	o	o
Difficult Breathing	o	o
GENITO-URINARY SYSTEM		
Frequent Urination	o	o
Bladder Trouble	o	o
Excessive Urine	o	o
Scanty Urination	o	o
Painful Urination	o	o
Discolored Urine	o	o

DO NOT WRITE BELOW THIS LINE (DOCTOR USE ONLY)

SURGERY ____

MEDICATIONS ____

ACCIDENTS ____

FAMILY ____