## 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 _____ Alberta Health Care #: _____

Emergency contact name and phone number: _____

Is this a Workers Compensation claim? Yes / No **PAYMENT IS EXPECTED AT TIME OF VISIT**

Who may we thank for the referral? _____

**PRESENT COMPLAINTS**

What is your major complaint today? _____

How did this complaint occur? _____

When did it start? _____

Previous history of this complaint? _____

Has your pain been getting better, worse or no change? _____

Are you experiencing any numbness, tingling or radiating pain? ☐ Yes ☐ No (Please mark on diagram on next page)

Are symptoms better or worse during morning, mid-day or night? _____

Can you perform activities of daily living? ☐ Yes ☐ No

Describe: _____

What makes pain worse? _____

What makes pain better? _____

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: _____

On a scale of 1-10 (1 least pain -> 10 worst pain) how severe is your pain: 1 2 3 4 5 6 7 8 9 10

Please use the following symbols to indicate on the diagram the symptoms you are currently experiencing:

Numbness (decreased sensation): = = = = = = =

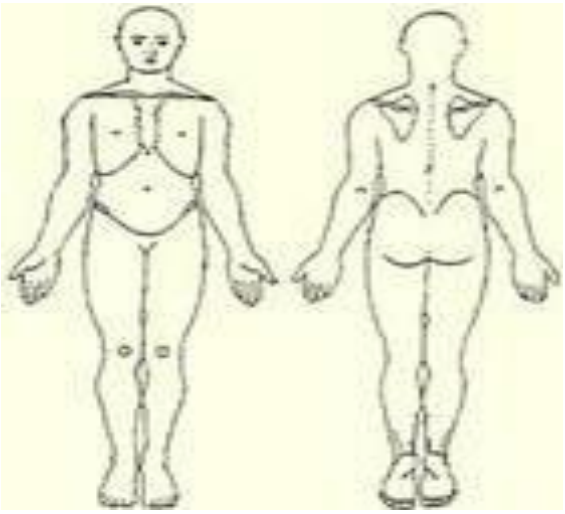
Dull ache: o o o o o o o o

Burning: x x x x x x x

Sharp/stabbing: / / / / / /

Pins/needles: + + + + + +

Other: _____ ^ ^ ^ ^ ^ ^



Have you seen other health care practitioners about this complaint? Whom? _____

Previous Chiropractor: _____ Last Visit Date: _____

Reason for previous chiropractic treatment: _____

Is there any history of stroke, cancer, diabetes or arthritis (or other health condition) in your family? ☐ Yes ☐ No

Describe:_____

**HABITS & VITAMINS**

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

Explain: _____

Vacations (How often?) _____ Exercise (How often?) _____

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

Tobacco (How much?) _____ Diet (Allergies / Intolerances) _____

Vitamins:_____

Medications: _____

Current Health Conditions: _____

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

Previous trauma/motor vehicle accidents: _____

Previous surgeries: _____

**SYSTEMS REVIEW**

**Circle** any conditions that are **presently** causing you a problem.
**Underline** those that have caused you problems in the **past**.

### GENERAL SYMPTOMS

Fever
Sweats
Fainting
Sleep disturbance
Fatigue
Nervousness
Weight loss
Weight gain

### RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Wheezing
Difficulty breathing
Asthma

### GENITOURINARY

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Prostate trouble
Uncontrollable urine flow

### NEUROLOGICAL

Visual disturbance
Dizziness
Fainting
Convulsions
Headache
Numbness
Neuralgia (nerve pain)
Poor coordination
Weakness

### CARDIOVASCULAR

Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Hardening of arteries
Swollen ankles
Poor circulation
Palpitations
Cold hand or feet
Varicose veins

### GASTROINTESTINAL

Poor appetite
Difficult digestion
Heartburn
Ulcers
Nausea
Vomiting
Constipation
Diarrhea
Blood in stool
Gallbladder/jaundice
Colitis

### EYES, EARS, NOSE, THROAT

Eye pain
Double vision
Ringing in ears
Deafness
Nosebleeds
Trouble swallowing
Hoarseness
Sinus infection
Nasal drainage
Enlarged glands

### MUSCLE & JOINT

Neck pain
Low back pain
Arm pain
Shoulder pain
Leg pain
Knee pain
Foot pain
Pain/numbness down arms or legs
Pain between shoulders Swollen joints
Spinal curvature
Arthritis
Fractures

### FOR WOMEN ONLY

Painful menstruation
Hot flashes
Irregular cycle
Cramps or back pain
Vaginal discharge
Nipple discharge
Lumps in breast
Menopausal symptoms
Birth control pills
Miscarriages
Complications with pregnancy
Pregnant? Y / N Week? ___
Other:

Please circle if you have had any of the following:

Stroke Cancer Diabetes Arthritis Tuberculosis Alcoholism Hypoglycemia Epilepsy

Allergies Rheumatic Fever Heart Disease S.T.D.