Patient Information Form

Name:________________________________ Birth date: _______________ Marital Status: **S M CL W D**
(please circle one)

Address:______________________________ City:______________________ Postal Code:__________

Home Phone#:_____________ Work#:_____________ Cell #:____________ Pager#:____________

E-mail address:________________________________ Referred to us by:________________________

Occupation:___________________________ Employer:_______________________________________

Emergency Contact:___________________, relation to you:________________ Phone#:__________
Family Physician:_____________________________ Location:__________________________________

Is this condition part of an ICBC or WCB claim? **Y/N** **If yes, please ask for additional forms.**
Have you obtained an attorney? **Y/N** If yes, attorney's name:__________________________________

What is your major complaint? ____
____
Other complaints?____
____

Are these symptoms: **A)** getting worse **B)** improving **C)** about the same **D)** come and go ?

Please circle any activities that aggravate your condition:
A) standing **B)** sitting **C)** walking **D)** lying **E)** bending **F)** lifting **G)** twisting **H)** coughing
Have you had these symptoms before? **Y/N** If yes, when?____________________________________

Have you had prior chiropractic care? **Y/N** If yes, doctor's name:______________________________

Have you seen another doctor for THIS condition? **Y/N** If yes, doctor's name:__________________
Date consulted:___________________, diagnosis:______________________ Were X-rays taken? **Y/N**

Are you on ANY medication? **Y/N** If yes, please list:____
____
____
Have you EVER been in a motor vehicle accident? **Y/N** If yes, when?: _________________________
Female only: Are you pregnant? **Yes/No/Maybe**

I hereby acknowledge that all of the information herein is correct to the best of my ability:

Signature of Patient:_____________________________________ Date:__________________________
-or parent/guardian if under 19 years

Please complete reverse side⇒ ⇒ ⇒

PATIENT PAST HISTORY FORM

Name:____ Date:____________________

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

C=Constant F=Frequent O=Occasional

C F O

NEUROLOGICAL

☐ ☐ ☐ allergy
☐ ☐ ☐ chills
☐ ☐ ☐ convulsions
☐ ☐ ☐ dizziness
☐ ☐ ☐ fainting
☐ ☐ ☐ fevers
☐ ☐ ☐ headaches
☐ ☐ ☐ loss of sleep
☐ ☐ ☐ nervousness
☐ ☐ ☐ depression
☐ ☐ ☐ neuralgia
☐ ☐ ☐ numbness
☐ ☐ ☐ sweats
☐ ☐ ☐ loss of weight
☐ ☐ ☐ tremors

MUSCLE & JOINT

☐ ☐ ☐ arthritis
☐ ☐ ☐ bursitis
☐ ☐ ☐ foot trouble
☐ ☐ ☐ hernia
☐ ☐ ☐ low back pain
☐ ☐ ☐ neck pain
☐ ☐ ☐ neck stiffness
☐ ☐ ☐ pain between shoulders

RESPIRATORY

☐ ☐ ☐ chronic cough
☐ ☐ ☐ wheezing
☐ ☐ ☐ difficulty breathing
☐ ☐ ☐ spitting blood
☐ ☐ ☐ throat phlegm

EYES,EARS, NOSE & THROAT

☐ ☐ ☐ colds
☐ ☐ ☐ crossed eyes
☐ ☐ ☐ deafness
☐ ☐ ☐ dental decay
☐ ☐ ☐ asthma
☐ ☐ ☐ ear aches
☐ ☐ ☐ ear discharges
☐ ☐ ☐ ear noises

C F O

☐ ☐ ☐ sinus infections
☐ ☐ ☐ enlarged glands
☐ ☐ ☐ sore throat
☐ ☐ ☐ tonsillitis
☐ ☐ ☐ eye pain
☐ ☐ ☐ failing vision
☐ ☐ ☐ far sighted
☐ ☐ ☐ gum trouble
☐ ☐ ☐ hay fever
☐ ☐ ☐ hoarseness
☐ ☐ ☐ nasal obstruction
☐ ☐ ☐ near sighted
☐ ☐ ☐ nosebleeds

CARDIO-VASCULAR

☐ ☐ ☐ slow heart beat
☐ ☐ ☐ rapid heart beats
☐ ☐ ☐ hardening of arteries
☐ ☐ ☐ high blood pressure
☐ ☐ ☐ low blood pressure
☐ ☐ ☐ pain over heart
☐ ☐ ☐ swelling of ankles
☐ ☐ ☐ poor circulation

GASTRO INTESTINAL

☐ ☐ ☐ excessive hunger
☐ ☐ ☐ burping or gas
☐ ☐ ☐ liver trouble
☐ ☐ ☐ colitis
☐ ☐ ☐ colon trouble
☐ ☐ ☐ constipation
☐ ☐ ☐ diarrhoea
☐ ☐ ☐ difficult digestion
☐ ☐ ☐ distension of abdomen
☐ ☐ ☐ stomach pain
☐ ☐ ☐ gall bladder trouble
☐ ☐ ☐ haemorrhoids
☐ ☐ ☐ intestinal worms
☐ ☐ ☐ jaundice
☐ ☐ ☐ poor appetite
☐ ☐ ☐ nausea
☐ ☐ ☐ vomiting
☐ ☐ ☐ vomit blood

C F O

SKIN

☐ ☐ ☐ boils
☐ ☐ ☐ bruise easily
☐ ☐ ☐ dryness
☐ ☐ ☐ hives or allergy
☐ ☐ ☐ itching
☐ ☐ ☐ skin rash
☐ ☐ ☐ varicose veins

GENITO-URINARY

☐ ☐ ☐ bed wetting
☐ ☐ ☐ blood in urine
☐ ☐ ☐ frequent urination
☐ ☐ ☐ loss control urine
☐ ☐ ☐ kidney infection
☐ ☐ ☐ painful urination
☐ ☐ ☐ prostate trouble
☐ ☐ ☐ pus in urine
☐ ☐ ☐ smell in urine

PAIN OR NUMBNESS IN:

☐ ☐ ☐ shoulders
☐ ☐ ☐ arms
☐ ☐ ☐ hands
☐ ☐ ☐ hips
☐ ☐ ☐ legs
☐ ☐ ☐ knees
☐ ☐ ☐ ankles
☐ ☐ ☐ feet
☐ ☐ ☐ painful tail bone
☐ ☐ ☐ sciatica
☐ ☐ ☐ swollen joints

FOR WOMEN ONLY

☐ ☐ ☐ cramps
☐ ☐ ☐ heavy flow
☐ ☐ ☐ light flow
☐ ☐ ☐ irregular cycle
☐ ☐ ☐ painful cycle
☐ ☐ ☐ discharge
☐ ☐ ☐ sore breasts

Menopausal: YES / NO Pregnant: YES / NO

Last menstruation date: _____________

Due date if pregnant :_______________