CONFIDENTIAL PERSONAL INFORMATION **DATE:** ___________________________

Name _______________________________________ Alberta Health Care # _______________ Age _____ Sex: M F

How do you wish to be addressed in the clinic:____

Address: ____ City: ____________________ Postal Code: _______________

Home Phone: ____________________ Cellular phone: _____________________ Work phone: _____________________

E-Mail address: _________________________________ Height: ________ Weight: _________ Right or Left Handed

Birthdate(dd/mm/yyyy): ______________ Marital status: S M D W How many children? _____ Their ages? __________

Occupation: ____________________________________ Employer: ____

Name of wife / husband / partner: ______________________________ His / her occupation: _________________________

Who referred you to our office? _________________________ or ☐ internet ☐ phonebook ☐ location other ____________

Previous chiropractor: _____________________________________ Date of last visit: _____________________________

Family physician: ____ Date of last visit: _____________________________

Are you presently taking medication or pain killers? If yes, list: ____

Have you ever had an: ☐ Auto Accident (year) ____________________ ☐ Work Injury (year) ______________________

☐ Sports Injury (year) ___________________ ☐ Other: _______________________________

List any surgeries you have had and when: ____

Do you have any other health insurance privately or through work? ☐ yes ☐ no ☐ not sure

What is your reason for coming to our office? Increase my general health maintenance specific symptom

If you came in with specific symptoms, what is your major complaint? ____

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

What is **your goal** that you would like to achieve by having your maximum health restored? (for example, playing with grandchildren, sleeping without pain, etc.)____

____

On a scale of 1 -10 how are you feeling: Very poorly 0 1 2 3 4 5 6 7 8 9 10 very well

Do you own a core stability ball? ☐ Yes ☐ No

Are you affected by any of the following? Please check ☐: **O** = occasionally **F** = Frequently **C** = Constant

	O	F	C
Neck Pain/stiffness	☐	☐	☐
Mid Back Pain	☐	☐	☐
Low Back Pain	☐	☐	☐

PAIN OR NUMBNESS IN

L R Shoulder
L R Arm
L R Elbow
L R Hands
L R Fingers

L R Hip
L R Leg
L R Knee
L R Ankle
L R Foot
L R Toes

	O	F	C
Headaches/Migraines	☐	☐	☐
Dizziness	☐	☐	☐
Nervousness	☐	☐	☐
Depression	☐	☐	☐
Heart Conditions	☐	☐	☐
Difficulty Breathing	☐	☐	☐
Allergies	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Sinus Problems	☐	☐	☐
Head Colds	☐	☐	☐
Runny Nose	☐	☐	☐
Sore Throat	☐	☐	☐
Cough	☐	☐	☐

	O	F	C
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Gas Pain	☐	☐	☐
Irritable Bowel	☐	☐	☐
Bladder Problems	☐	☐	☐
Control of Urination	☐	☐	☐
Kidney Problems	☐	☐	☐
Prostate Problems	☐	☐	☐
Stomach Problems	☐	☐	☐
Heartburn	☐	☐	☐

	Yes	No
Cancer	☐	☐
Heart disease	☐	☐
Diabetes	☐	☐

Females Only:	O	F	C
Painful menstruation	☐	☐	☐

Are You Pregnant? yes☐ no☐

Last Menstruation:___________

Please list any other conditions that you are seeing a medical doctor for:__________

____

____

____