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	☐	☐	☐

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

_____

_____

_____

Are You Pregnant? yes☐ no☐

Last Menstruation:_____