

# PERSONAL HISTORY

## Dear Patient:

Please complete this questionnaire. Your answers will help determine if Chiropractic can help you. Please answer ALL questions, even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unaware of. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name: \_\_\_\_\_ Date \_\_\_\_\_ Case# \_\_\_\_\_

Health Ins. No. \_\_\_\_\_ Phone: Home \_\_\_\_\_ Office \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Marital Status \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Children \_\_\_\_\_

Birthdate \_\_\_\_\_ Birthplace \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Family M.D. \_\_\_\_\_

Referred to this office by \_\_\_\_\_

Who is responsible for your bill?  Self  Spouse  Parent or Guardian  Other \_\_\_\_\_

Insurance other than AHC? (London Life, Great West, Blue Cross, etc.) \_\_\_\_\_

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## CURRENT HEALTH CONDITION

Present complaint \_\_\_\_\_

Have you had any previous treatment for this condition? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

What do you believe caused this condition? \_\_\_\_\_

Are there others in your family with this same condition? \_\_\_\_\_

Have you had any time loss from work for this condition? (If recent list dates) \_\_\_\_\_

Is this a WCB Case? \_\_\_\_\_ If Yes - Social Insurance # & date of accident \_\_\_\_\_

Are you presently taking medication? (please mention) \_\_\_\_\_

When is the last time you really felt well? \_\_\_\_\_

How important is your health to you on a scale of 1-10, 10 being most important? \_\_\_\_\_

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## PAST HEALTH HISTORY

Major surgery/operations:  Appendix  Tonsils  Gall Bladder  Hernia  
 Heart  Back  Neck  Leg  Other \_\_\_\_\_

Major accidents or falls: (please describe) \_\_\_\_\_

Previous Chiropractic Care: Doctor's name and approximate date of last visit \_\_\_\_\_

Have you been treated for any health condition in the last year?  Yes  No

If yes, please explain \_\_\_\_\_

Check any conditions which are presently causing you a problem.  
Please underline which were a problem in the past.

**GENERAL**

- headache
- numbness or pain in arms or legs
- dizziness
- ringing in ears
- whiplash
- fainting
- earache
- sore throat
- nose bleeds
- sinus problems
- asthma
- enlarged glands
- loss of weight
- hypoglycemia
- nervousness
- depression/confusion
- vision problems
- dental problems
- hearing problems

**ORGANS**

- frequent urination
- painful urination
- blood in urine
- bladder trouble
- kidney stones
- bed wetting
- prostate problems
- sexual dysfunction
- anemia
- thyroid
- excessive appetite
- gas/bloating
- nausea or vomiting
- constipation/diarrhea
- colitis
- black/bloody stool
- hemorrhoids
- liver trouble
- gall bladder trouble

**SKIN**

- eczema
- skin eruptions
- varicose veins

**MUSCLE & JOINT**

- low back problems
- neck problems
- sore joints
- painful tailbone
- pain between shoulders
- spinal curvature
- arthritis
- sore muscles
- walking problems
- broken bones
- difficulty chewing/ clicking jaw
- ankle swelling
- limb pain

**RESPIRATORY & HEART**

- lung problems
- chronic cough
- spit up blood
- frequent colds/flu
- shortness of breath/ difficult breathing
- heart problems

**FEMALES ONLY**

- painful periods
- irregular cycle
- cramps, backache
- vaginal discharge/infection
- lumps/pain in breast
- menopausal symptoms
- previous miscarriage
- unable to get pregnant
- hot flashes
- are you pregnant?  
 Yes  No  Not Sure
- when was your last period?  
\_\_\_\_\_

Check any of the following diseases you have had:

- alcoholism
- venereal infection
- epilepsy
- stroke
- arthritis
- hypoglycemia
- tuberculosis
- rheumatic fever
- diabetes
- cancer
- allergies
- heart disease

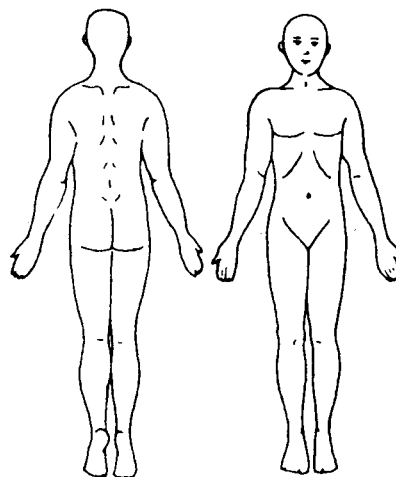
Has anyone in your family had any of the following diseases?

- heart disease
- high blood pressure
- cancer
- stroke
- arthritis

**HABITS**

	None	Light	Moderate	Heavy
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Junk Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please outline on the diagram the area of your discomfort.



**DO NOT WRITE BELOW THIS LINE — DOCTOR ONLY**

Diagnosis \_\_\_\_\_

Patient accepted:  Yes  No  Referred

Doctor's Signature \_\_\_\_\_

Why Chiropractic? People go to Chiropractors for a variety of reasons, Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (**Preventive Care**). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, this prepared recommendation is in incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care       Corrective Care       Preventive Care       Check here if you want the doctor to select the type of care appropriate for your condition.

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Date

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Patient's Signature

## INFORMED CONSENT

PHYSICIANS, CHIROPRACTORS, OSTEOPATHS AND PHYSIOTHERAPISTS ARE REQUIRED TO ADVISE PATIENTS WITH NECK PROBLEMS, SUCH AS YOURS, OF THE FOLLOWING:

IN RECENT YEARS THERE HAVE BEEN INCIDENTS OF INJURY TO THE VERTEBRAL ARTERY DURING THE COURSE OF TREATMENT. THIS HAS CAUSED STROKES OR STROKE LIKE OCCURRENCES, WHICH ARE USUALLY OF A TEMPORARY NATURE. THE CHANCES OF THIS HAPPENING ARE BETWEEN ONE IN ONE MILLION AND ONE IN ONE AND ONE HALF MILLION. TESTS, WITH OR WITHOUT X-RAYS, HAVE BEEN PERFORMED ON YOU TO MINIMIZE THIS RISK TO YOURSELF. CHIROPRACTIC IS CONSIDERED TO BE ONE OF THE SAFEST AND MOST EFFECTIVE FORMS OF THERAPY FOR YOUR TYPE OF PROBLEM. IF YOU HAVE ANY QUESTIONS ABOUT THIS, PLEASE ASK YOUR CHIROPRACTOR.

I HAVE READ THE ABOVE STATEMENT AND CONSENT TO TREATMENT.

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DATE

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PATIENT'S SIGNATURE