

PERSONAL HISTORY

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

Name: _____ Date: _____

Address: _____ Town/City: _____ Postal Code: _____

Phone #: Home: _____ Work: _____ Cell: _____

E-Mail: _____

AB Personal Health #: _____ Birthdate (dd/mm/yyyy): _____

Sex: ___ M ___ F Height: _____ Weight: _____ Marital Status: _____ Children: _____

Birthplace: _____ Employer: _____ Occupation: _____

Family M.D.: _____ Referred to this office by: _____

Who is responsible for your bill?

Self ___ Spouse ___ Parent or Guardian ___ Other ___

CURRENT HEALTH CONDITION

Present Complaint/Condition: _____

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, please notify receptionist immediately.

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? _____

Please list all prescription and non-prescription medications you are presently taking:

_____**PAST HEALTH HISTORY**

Major Surgery/Operations:

___ Appendix ___ Tonsils ___ Gall Bladder ___ Hernia
___ Heart ___ Back ___ Neck ___ Knee ___ Other

Major Accidents/Falls: (please describe)

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

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

If yes, please explain: _____

Name: _____

Case#: _____

Please **check** any condition, which are *presently* causing you a problem.

Please underline which have been problems in the *past*.

GENERAL

- Headache
- Numbness/Pain in Legs
- Numbness/Pain in Arms
- Dizziness
- Ringing in ears
- Whiplash
- Fainting
- Earache
- Sore Throat
- Nose Bleeds
- Sinus Problems
- Asthma
- Enlarged glands
- Loss of Weight
- Hypoglycemia
- Nervousness
- Depression
- Confusion
- Hearing problems
- Dental problems
- Vision problems
- _____
- _____
- _____
- _____

ORGANS

- Frequent Urination
- Blood in Urine
- Constipation/Diarrhea
- Bladder trouble
- Kidney Stones
- Bed Wetting
- Prostate Problems
- Sexual Dysfunction
- Anemia
- Thyroid
- Excessive Appetite
- Gas/Bloating
- Nausea or Vomiting
- Colitis
- Black/Bloody Stool
- Hemorrhoids
- Gall Bladder Trouble
- _____
- _____
- _____

SKIN

- Eczema
- Skin Eruptions
- Varicose Veins
- Psoriasis
- Acne
- _____

RESPIRATORY & HEART

- Lung Problems
- Chronic Cough
- Spit up blood
- Frequent Colds/Flu
- Shortness of breath
- Difficulty Breathing
- Heart Problems
- _____

MUSCLE AND JOINT

- Low Back Problems
- Neck Problems
- Sore Joints
- Painful Tailbone
- Pain between Shoulders
- Spinal Curvature
- Arthritis
- Sore Muscles
- Walking Problems
- Broken Bones
- Difficulty Chewing
- Ankle Swelling
- Limb Pain
- _____
- _____
- _____

FEMALES ONLY

- Painful Periods
- Irregular Cycle
- Cramps/Backache
- Vaginal Discharge
- Vaginal Infection
- Lumps/Pain in breast
- Previous Miscarriage
- Unable to get Pregnant
- Menopausal Symptoms

Are you pregnant?

- Yes
- No
- Not Sure

When was your last period

Date _____

Please check any of the following you have experienced or have had treatment for:

- Alcoholism
- Allergies
- Arthritis
- Cancer
- Diabetes
- Epilepsy
- Heart Disease
- Hypoglycemia
- Mental Illness
- Stroke
- Rheumatic Fever
- Tuberculosis
- Venereal Infection

Has anyone is your family had any of the following?

- Arthritis
- Cancer
- Heart Disease
- High Blood Pressure
- Stroke
- Diabetes

Please **mark** the area of discomfort/problem on the diagram

HABITS	None	Low	Med	High
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"/>
Water	<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/Pop	<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"/>

