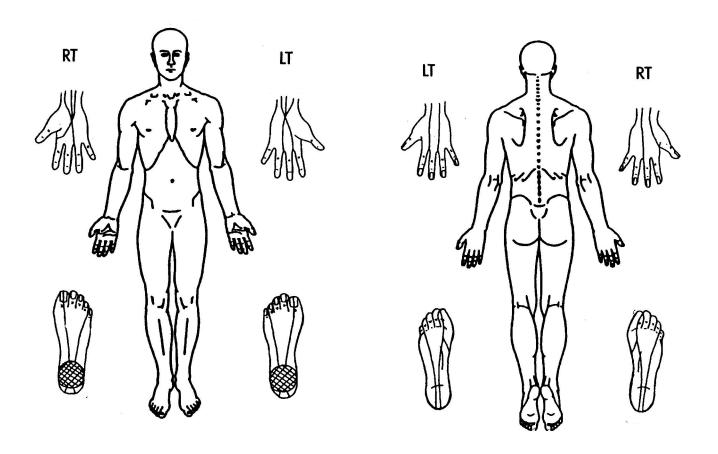
Patient Information Package

Name:	
Address:street	Postal code:
Telephone: home: ()work: ()	ext: cell:()
Employer:	Occupation(s):
Date of Birth://	E-mail:
Primary Health Care Physician:	
Sex: F M Height: Weight: How	did you learn about us:

Please indicate on the diagram your present concerns with the following symbols:

PAIN Circle Numbness XXXX Tingling /////// Aches/Tight ******



Frimary Complaint Details		
What is your primary concern or s	ymptom:	
What happened to bring this on?		
When did this happen or start?		
Describe the symptom or problem		
• In frequency (how often):		
• In quality (sharp, dull, achy, thr	obbing,):	
What makes it feel better?		
Have you sought any treatment for	it? YES NO	
If yes, what kind?		
Did it work?		
Secondary Complaint Detai	ls (if present)	
What is your secondary concern or	symptom:	
When did this happen or start?		
How would you describe the symp	tom or problem?	
In frequency (how often):		
• In quality (sharp, dull, achy, thr	obbing,):	
Rate your pain out of 10:	(NO Pain)	
#1 complaint	1	10
#2 complaint_	1	10

\Box \forall Check box if **PRESENTLY** experiencing condition. Underline if in the PAST. (Circle) specifics ex: knee (foot G.U. for Women **General Symptoms** Cardiovascular Menstruation: Headaches / Migraine Heart murmur -painful Fever / Chills □ Heart disease □ -heavy / scant □ Night Sweats / Sweats ☐ History of heart attack -irregular Night Pain □ Pacemaker / other device -cramps / backache Weight Loss □ High / Low blood pressure Hot flashes Loss of sleep Stroke Menopause Clumsiness □ Angina □ Breast swollen / lumps □ Arteriosclerosis Pregnant: due date E.E.N.T. Bleeding disorders Birth control pill Cataracts Varicose veins Glaucoma **Phlebitis Systemic conditions** Blurred or loss of vision Swelling of ankles (indicate you or any family member) Eve pain □ Poor circulation □ Diabetes Contacts □ Cancer Ringing in the ears □ Heart disease / Stroke Gastrointestinal Earache Hypo / Hyper thyroid Poor appetite Deafness Gout Cravings: sweets/ starch/ other Speech problems Liver disease/ problems Indigestion Sore throat **Epilepsy** Stomach pain Difficulty swallowing Hepatitis Ulcer **Tuberculosis** Nausea Osteoporosis Vomiting / blood Muscles & Joints (stiff/pain) Belching / gas / bloating Neck **Immune system** Constipation Back: upper / lower Colds / Flu often Diarrhea Shoulder Allergies Hemorrhoids Sensitive to environment Elbow □ Gall bladder trouble Wrist / Hand Slow to heal □ Hiatus / inguinal hernia HIV + / AIDS Hip □ Crohn's / Colitis/ other Knee □ Irritable Bowel Ankle / Foot **Psychosocial** Arthritis RA/OA Daily Stress Genitourinary Swollen joints mild / moderate / extreme Painful urination Fractures ■ Emotional crisis Difficulty urinating Jaw problems Depression / Anxiety Blood in urine Psychiatric/Psychological care Kidney / bladder infection Addictions: Respiratory Stones □ Do / did you smoke? Y/ N Bed wetting #/day # yrs **Other Health Care** Prostate problems Chiropractic Chronic cough Spitting up phlegm / blood Massage therapy Skin Naturopath/Homeopath Chest pain Sensitive Craniosacral Difficulty breathing □ Rashes/itching Bronchitis Physiotherapy/Osteopathy □ Bruise easily Acupuncture / pressure Asthma Dryness Nutrition Emphysema Boils / hives Sinus problems Yoga, Tai Chi, Pilates Contagious condition Other: Herpes / Cold sores

Medical History			
_	egeries -list all hospitalization current related symposis, wires, prosthesis, canes and a		gested, dates and any
-			
<u>Injures</u> (incl. childhoo	od) list major injuries, car / bic	ycle accidents, any traumas, dates	and related symptoms
X-rays (CATs, MRIs)	and what were the results		
Medication / Supplem	-current and any major -supplements regularly	past medication, dosage and cond taken	ition treated
Activity -please list yo	our current (& past) physical ac	ctivity, and approximate number of	of hours/week.
Childhood History	(P. maggible adult aandit	tions)	
Ciliunoou History	(& possible adult condit	,	
 difficult birth complications premature baby colic Cesarean 	ear infectionstubes in earschicken poxmumps	whooping coughmeningitismeasleschronic illness	typhoid feverpoliorheumatic feverother

Lifestyle
Have you ever injured your <u>spine</u> ex: neck, head, back or hips (IF different from complaints)?
a) Date of most significant occurrence
b) What happened?
Have you consulted a physician or any other healthcare provider in the past three months? Yes No
If yes, please describe:
Do you have a meditation, prayer, nutritional or dietary program? Yes No
If yes, please describe:
When stressed, how do you cope or alleviate it?
Your specific needs and hopes for help in this office
What are the top 3 goals you would like to achieve through your chiropractic care? <u>Ex:</u> Reduce stress or pain, improve overall health, increase energy or quality of life, improve sports performance, etc
I)
II)
III)
I learn and respond best through the following:
Please circle one: hearing/listening seeing/visual experiencing/feeling
I am a person: Please circle one: I'm more people oriented or I'm more fact oriented Please circle one: I'm more apt to 'tell' or I'm more apt to 'ask'

Thank you for choosing our office.

We look forward to assisting you as you work towards greater health and wellness.