Patient Information Package

Name:_____

Address: _____ Postal code: _____
street city

Telephone: home: (___)_____ work: (___)_____ ext:_____ cell:(____)_____

Employer:_____ Occupation(s):_____

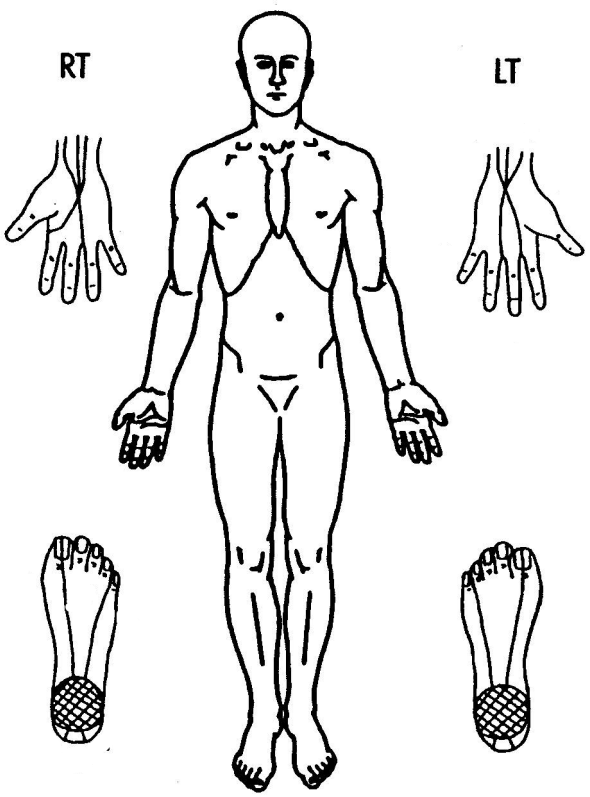
Date of Birth: _____/_____/_____ E-mail: _____
Day Month Year

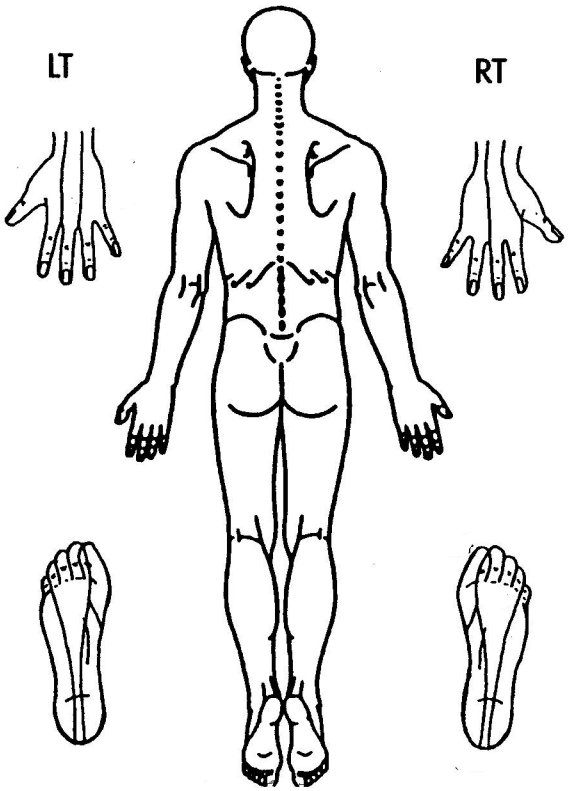
Primary Health Care Physician: _____

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** ******





Primary Complaint Details

What is your primary concern or symptom:_____

_____

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, throbbing,...):_____

What makes it feel better?_____

What makes it feel worse?_____

Have you sought any treatment for it? **YES NO**

If yes, what kind?_____

Did it work?_____

Secondary Complaint Details (if present)

What is your secondary concern or symptom:_____

When did this happen or start?_____

What happened to bring this on?_____

How would you describe the symptom or problem?

- In frequency (how often):_____
- In quality (sharp, dull, achy, throbbing,...):_____

What makes it feel better?_____

What makes it feel worse?_____

Rate your pain out of 10:	**(NO Pain)**	**(SEVERE Pain)**
#1 complaint_____	1_____	10
#2 complaint_____	1_____	10

❑ √ Check box if **PRESENTLY** experiencing condition. **Underline** if in the **PAST**.
Circle specifics *ex: knee / foot*

General Symptoms
- ❑ Headaches / Migraine
- ❑ Fever / Chills
- ❑ Night Sweats / Sweats
- ❑ Night Pain
- ❑ Weight Loss
- ❑ Loss of sleep
- ❑ Clumsiness

E.E.N.T.
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Blurred or loss of vision
- ❑ Eye pain
- ❑ Contacts
- ❑ Ringing in the ears
- ❑ Earache
- ❑ Deafness
- ❑ Speech problems
- ❑ Sore throat
- ❑ Difficulty swallowing

Muscles & Joints (stiff/pain)
- ❑ Neck
- ❑ Back: upper / lower
- ❑ Shoulder
- ❑ Elbow
- ❑ Wrist / Hand
- ❑ Hip
- ❑ Knee
- ❑ Ankle / Foot
- ❑ Arthritis RA / OA
- ❑ Swollen joints
- ❑ Fractures
- ❑ Jaw problems

Respiratory
- ❑ Do / did you smoke? Y/ N
  #/day _____ # yrs_____
- ❑ Chronic cough
- ❑ Spitting up phlegm / blood
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Sinus problems

Cardiovascular
- ❑ Heart murmur
- ❑ Heart disease
- ❑ History of heart attack
- ❑ Pacemaker / other device
- ❑ High / Low blood pressure
- ❑ Stroke
- ❑ Angina
- ❑ Arteriosclerosis
- ❑ Bleeding disorders
- ❑ Varicose veins
- ❑ Phlebitis
- ❑ Swelling of ankles
- ❑ Poor circulation

Gastrointestinal
- ❑ Poor appetite
  Cravings: sweets/ starch/ other
- ❑ Indigestion
- ❑ Stomach pain
- ❑ Ulcer
- ❑ Nausea
- ❑ Vomiting / blood
- ❑ Belching / gas / bloating
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ Gall bladder trouble
- ❑ Hiatus / inguinal hernia
- ❑ Crohn's / Colitis/ other
- ❑ Irritable Bowel

Genitourinary
- ❑ Painful urination
- ❑ Difficulty urinating
- ❑ Blood in urine
- ❑ Kidney / bladder infection
- ❑ Stones
- ❑ Bed wetting
- ❑ Prostate problems

Skin
- ❑ Sensitive
- ❑ Rashes/itching
- ❑ Bruise easily
- ❑ Dryness
- ❑ Boils / hives
- ❑ Contagious condition
- ❑ Herpes / Cold sores

G.U. for Women

Menstruation:
- ❑ -painful
- ❑ -heavy / scant
- ❑ -irregular
- ❑ -cramps / backache
- ❑ Hot flashes
- ❑ Menopause
- ❑ Breast swollen / lumps
- ❑ Pregnant: due date_____
- ❑ Birth control pill

Systemic conditions
(indicate you or any family member)
- ❑ Diabetes
- ❑ Cancer
- ❑ Heart disease / Stroke
- ❑ Hypo / Hyper thyroid
- ❑ Gout
- ❑ Liver disease/ problems
- ❑ Epilepsy
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Osteoporosis

Immune system
- ❑ Colds / Flu often
- ❑ Allergies
- ❑ Sensitive to environment
- ❑ Slow to heal
- ❑ HIV + / AIDS

Psychosocial
- ❑ Daily Stress
  mild / moderate / extreme
- ❑ Emotional crisis
- ❑ Depression / Anxiety
- ❑ Psychiatric/Psychological care
- ❑ Addictions:_____

Other Health Care
- ❑ Chiropractic
- ❑ Massage therapy
- ❑ Naturopath/Homeopath
- ❑ Craniosacral
- ❑ Physiotherapy/Osteopathy
- ❑ Acupuncture / pressure
- ❑ Nutrition
- ❑ Yoga, Tai Chi, Pilates
- ❑ Other: _____

Medical History

Hospitalization & Surgeries -list all hospitalizations and surgeries, performed or suggested, dates and any current related symptoms
(please notify us of any pins, wires, prosthesis, canes and any other special equipment)

Injures (incl. childhood) list major injuries, car / bicycle accidents, any traumas, dates and related symptoms

X-rays (CATs, MRIs) and what were the results _____

Medication / Supplements -current and any major past medication, dosage and condition treated
-supplements regularly taken

Activity -please list your current (& past) physical activity, and approximate number of hours/week.

Childhood History (& possible adult conditions)

- ❑ difficult birth
- ❑ complications
- ❑ premature baby
- ❑ colic
- ❑ Cesarean
- ❑ ear infections
- ❑ tubes in ears
- ❑ chicken pox
- ❑ mumps
- ❑ whooping cough
- ❑ meningitis
- ❑ measles
- ❑ chronic illness
- ❑ typhoid fever
- ❑ polio
- ❑ rheumatic fever
- ❑ other _____

Lifestyle

Have you ever injured your spine 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?
Ex: 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.