Barnes Family Chiropractic

21-620 Davenport Rd. Waterloo ON N2V 2C2 519-725-4242
1204 Queen's Bush Rd. Wellesley ON N0B 2T0 519-656-9292

Welcome to our office

To ensure your visit with us is a pleasant one, here are the procedures you can expect during the next 60 minutes.

PAPERWORK	Complete this brief questionnaire and your health history form to help us to get to know you. The Doctor will use this information to help formulate the recommendations for your care.
CONSULTATION	The Doctor will review your history and determine if yours is a chiropractic case. You will be informed of the cost of any office procedures before they are performed.
EXAMINATION	Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause(s) of your subluxation.
SPINAL IMAGES	Necessary views may be taken to visualize the location of any spinal problems, neurological interferences, reveal any pathologies, and make your chiropractic care more precise.
CORRELATION	Before proper care can be rendered, the Doctor will study your examination findings. Later, you will see x-rays, review your findings and receive specific care and recommendations from the Doctor.

CONFIDENTIAL PATIENT CASE HISTORY – GENERAL INFORMATION

❑ Miss ❑ Mrs. ❑ Ms. ❑ Mr. ❑ Dr. How would you like to be addressed? _____
Name _____ Date _____
Address_____ City _____ Postal Code _____
Home Phone _____ Business Phone _____Ext. _____ Cellular_____
Date of Birth _____/_____/_____ Email _____ Sex ❑ Male ❑ Female Age _____
Year Month Day
Occupation or Profession _____ Employed by _____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Number of children _____
Name of Medical Doctor _____ Names & Ages _____
Spouses Name _____ Spouses Occupation _____
Who may we thank for referring you to our office today? _____

Extended Coverage

❑ Yes ❑ No
Amount of Chiropractic coverage_____Orthotic coverage_____
Spouses coverage _____

What is your major complaint for which you are seeking chiropractic care? _____
_____
_____

Have you ever received Chiropractic care? Yes No
If yes, when? _____ With who? _____

Please continue on the reverse side.

About your Health…

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in your lowered state of health. At your report of findings, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

PRESENT HEALTH: Are you presently affected by any of the following? (within past 3 months)

O – occasional F – Frequent C – constant

MUSCLE AND JOINT	O	F	C
Backache	❑	❑	❑
Neck pain	❑	❑	❑
Painful tailbone	❑	❑	❑
Foot trouble	❑	❑	❑
Shoulder pain	❑	❑	❑
Hernia	❑	❑	❑
Spinal curvature	❑	❑	❑
Faulty posture	❑	❑	❑
Arthritis	❑	❑	❑

GENERAL SYMPTOMS	O	F	C
Fever/Chills/Sweat	❑	❑	❑
Fainting	❑	❑	❑
Convulsions	❑	❑	❑
Allergy	❑	❑	❑
Skin problems	❑	❑	❑
Colds	❑	❑	❑
Tremors	❑	❑	❑
Loss of balance	❑	❑	❑

GASTROINTESTINAL	O	F	C
Difficult digestion	❑	❑	❑
Belching or gas	❑	❑	❑
Nausea or vomiting	❑	❑	❑
Pain over stomach	❑	❑	❑
Constipation	❑	❑	❑
Colon trouble	❑	❑	❑
Liver trouble	❑	❑	❑
Gall bladder trouble	❑	❑	❑
Heartburn	❑	❑	❑
Diarrhea	❑	❑	❑
Bloody stools	❑	❑	❑

CARDIOVASCULAR	O	F	C
Rapid heart beat	❑	❑	❑
Slow heart beat	❑	❑	❑
High blood pressure	❑	❑	❑
Low blood pressure	❑	❑	❑
Pain over heart	❑	❑	❑
Swelling of ankles	❑	❑	❑
Previous heart attack	Yes❑	No❑	
Poor circulation	Yes❑	No❑	
Previous stroke	Yes❑	No❑	

STRESS SYMPTOMS

Headaches	❑	❑	❑
Migraines	❑	❑	❑
Dizziness	❑	❑	❑
Numbness or pins & needles in:			
Arms or hands	❑	❑	❑
Legs or feet	❑	❑	❑
Ringing in ears	❑	❑	❑
Blurring of vision	❑	❑	❑
Loss of sleep	❑	❑	❑
Loss of concentration/memory	❑	❑	❑
Irritable/Nervousness.	❑	❑	❑
Depression	❑	❑	❑
Decreased energy/fatigue	❑	❑	❑
Tension	❑	❑	❑

RESPIRATORY

Chronic cough	❑	❑	❑
Spitting up phlegm and/or blood	❑	❑	❑
Chest pain	❑	❑	❑
Difficult breathing	❑	❑	❑

URINARY

Painful urination	❑	❑	❑
Getting up at night to urinate	❑	❑	❑
Blood in urine	❑	❑	❑
Increased urination	Yes❑	No❑	

EYES, EARS, NOSE, THROAT

Deafness	❑	❑	❑
Earache	❑	❑	❑
Sore throat	❑	❑	❑
Asthma	❑	❑	❑
Tonsillitis	❑	❑	❑
Sinus trouble	❑	❑	❑

FEMALES ONLY

Painful menstruation	Yes❑	No❑
Excessive flow	Yes❑	No❑
Irregular	Yes❑	No❑
Cramps or backache	Yes❑	No❑
Passed menopause	Yes❑	No❑
Are you pregnant	Yes❑	No❑
Birth control pill	Yes❑	No❑

No. of pregnancies _____
No. of children _____
No. of miscarriages _____
Date of last menstrual period
_____

PAST HEALTH: Have you ever suffered from any of the following conditions?

	Yes	No		Yes	No		Yes	No		Yes	No
Thyroid trouble	❑	❑	Tuberculosis	❑	❑	Emotional problems	❑	❑	Psoriasis	❑	❑
Diabetes	❑	❑	Pneumonia	❑	❑	Epileptic seizures	❑	❑	Polio	❑	❑
High blood pressure	❑	❑	Back pain	❑	❑	Asthma	❑	❑	Cancer	❑	❑
Heart disease	❑	❑	Headaches	❑	❑	Arthritis	❑	❑	Venereal disease	❑	❑
Allergies	❑	❑	Stomach ulcers	❑	❑	Alcoholism	❑	❑	HIV	❑	❑

Please list any significant illness, operations, accidents, falls, or traumas

Date	Illness/ Operation / Accident/ Falls

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients of benefits and risks including sprain/strain, rib fracture, disc herniation and with neck problems of the following: There have been very rare 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 less than one in ten million. Tests, with or without x-rays have been performed on you to minimize these risks to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this please ask your Chiropractor.

If you read the above statement and consent to treatment.

Signature _____ Date signed _____

Thank you for completing this form. We certainly hope that we can help you attain optimal health.