Information reviewed with patient　　　　Todays date ___________________

Dr. Initials_______

Name: L ______________________________ F ______________________________ Sex: Male _____Female _______

Address:____

City: ______________________________Postal Code:________________

Home Phone: # _______________________Work: # _______________________Cell: #_______________________

Email: _____________________________________ ☐ I do not want to be contacted via email

Height: ______ Weight:______lbs. Date of Birth: _____________________Age: _________________________

Occupation: _____________________________________Employer_______________________________________

Spouse's Name: ____

Name of Children and Ages: ____

BC Health Care #: ____

Have you ever received Chiropractic care? Yes / No

If yes, who from and what for? ____ When:__________________

How did you find out about our office? ____

If you were referred to our office, who may we thank? ___________________________________

Have you received spinal x-rays in the last 2 years? Yes / No

Do you wear orthotics or special shoe inserts? Yes / No (if yes, how old are they?) ______________________

If yes, Date:______________________________

Is this related to a Motor Vehicle Accident in the **last 10 days**? Yes / No. If yes is this an insurance claim? Yes / No

Is this a work-related injury (***WCB Claim***)? Yes / No

Is there a chance you could be **pregnant**? Yes / No

Existing Symptoms

If you have a chief complaint(s), please describe briefly: (include how and when problem started)

____

____

____

CIRCLE ALL THAT APPLY

The problem occurred: Gradually Suddenly

Condition is worse with: Right rotation / Left rotation / forward bending / backward bending/ right bending/ left

Is the condition: Intermittent Constant

Is it worse in the: Am PM Same

Does it radiate? Yes / No If yes, where? ____

Is the pain getting progressively worse? Yes / No

Have you had this problem in the past? Yes / No

The condition interferes with my: Sleep Work Daily Routine Family Life Exercise Mood

What activities aggravate your pain/condition?

____

What (if anything) relieves your pain/condition?

____

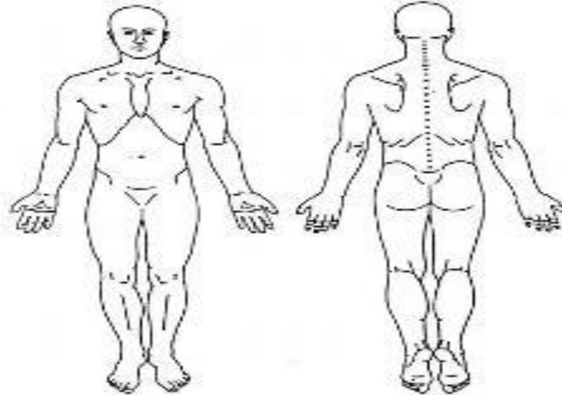
Have you received treatment for this issue? Yes / No If yes, what and did it help?

____

Pain Diagram

Mark the areas on this body where you feel the described sensation. Use the appropriate symbols.

Aching (**), Burning (- -), Stabbing (//) Numbness (XX), Pins/Needles (++),



On a scale between 0 (no pain) and 10 (intense pain) Circle where you are currently at:

0----1----2----3----4----5----6----7----8----9----10

System Review

Please indicate by circling any of the following conditions you may be experiencing or have experienced in the past

Headaches	Shoulder pain	Constipation / Diarrhea
Migraines	Depression / anxiety	Low back pain
Neck pain	Upper back pain	Diabetes
Chronic fatigue	Chronic nausea	Blood pressure problems
Ringing in the ears	Mid back pain	Cancer
Dizziness	Heartburn	Foot pain
Ear infections	Digestive issues	Bladder problems
Sinus problems	Asthma	Sexual dysfunction
Swallowing difficulties	Difficulty breathing	Allergies
Vision changes	Chest pain	Osteoporosis
Sleeping problems	Heart irregularities	Arthritis
Wrist pain	stroke	Cramping in the legs
Carpal tunnel	Leg pain	Scoliosis
Arm pain	Knee pain	Degenerative disc

Is there family history of (circle): Heart Disease   Stroke   Cancer   Diabetes   Other

Please list any vitamins or medications you are currently on: ______________________________
____
____

List any surgeries or hospitalizations you have had and include when: ________________________
____
____

Lifestyle Events and Habits

The 3 main stressors that may compromise your well-being:

Briefly describe any notable **injuries, head traumas, concussions, broken bones, slips or falls**
____
____

List any **motor vehicle accident** injuries: include date if known and describe collision (rear-end, rollover, etc.)
____
____

Circle what you spend most of your day doing:
Sitting / Bending Forward / Twisting / Lifting / Driving / Computer
If yes to sitting/driving/computer, how many hours per day do you spend at these activities? _____
Do you exercise on a regular basis?   Yes / No
Do you sleep on your: Back / Side / Stomach

Rate your posture out of 10 (0 - poor 10 - excellent):

0----1----2----3----4----5----6----7----8----9----10

Rate the amount of physical stress that your body goes through on a daily basis:
(0 - no physical stress 5 - moderate physical stress 10—heavy stress load):

0----1----2----3----4----5----6----7----8----9----10

Chemical Stress

Do you smoke?   Yes / No   If yes, how much and how long? ______________________________
Alcohol consumption: Yes / No   If yes, how much? Rarely   Weekly   Daily
My caffeine intake is: Low   Moderate   High
I eat processed foods: Rarely   Occasionally   Often
I use over the counter drugs (Aspirin, etc.):   Rarely   Occasionally   Often

Emotional Stress

My stresses include: Work Home School Finances Family
Relationships Health Problems Other? __________________________

Rate your stress level (0 - No stress 10 - Always stressed)

0----1----2----3----4----5----6----7----8----9----10