Personal History

Name: ______________________ Address: ______________________

Home #: ______________________ City: ______________________

Cell #: ______________________ Province: ____________ Postal Code: ____________

Birthdate (mm/dd/yyyy): ____________ Age: ____________ Sex: M ☐ F ☐ O ☐

Business/Employer: ______________________ Work #: ______________________

Type of Work: ______________________

Circle One: Married Single Common Law Widowed Divorced Separated Other Number of Children: _____

Emergency Contact: ______________ Phone #: ______________ Relationship: ____________

How did you hear about our clinic? ______________________

Email Address: ______________________ Do you approve email contact? _____ Initials

Past X-Rays (if applicable)

This will allow Balanced Wellness Family Chiropractic and its representatives access to any and all reports of X-Rays and or CT scans/MRI's, from within New Brunswick, regarding your current condition.

Medicare #: ______________ Province: ____ Patient Signature: ______________

Current Health Condition

Current Complaint(s): ______________________

____

____

Other doctors seen for this condition? ☐ Yes ☐ No Who? ______________________

Type of Treatment: ______________________ Results: ______________________

When did this condition begin? ______________ Has the condition occurred before? ☐ Yes ☐ No

Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: ______________

PLEASE NOTE THAT THIS OFFICE DOES NOT HANDLE WCB CLAIMS Initial: ________

What aggravates your condition? ______________________

What relieves your condition? ______________________

Circle a number to indicate the severity of your pain:

Slight 1 2 3 4 5 6 7 8 9 10 *Extreme*

At its worst, how old does this problem make you feel? ______________________

Do you suffer from any other condition than the one you are now consulting us for? ______________

____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: ______________

Have you had X-rays taken in the last six months? ☐ Yes ☐ No If yes, where? ______________

Past Health History

Current medications: ______________________

Major surgeries or traumas? ______________________

____

Current Health History

Name of Family Physician: ______________________

Do you have a regular exercise program? If yes, describe: ______________________

Lifestyle Stress Levels: Circle one **High** **Medium** **Low**

Do you smoke cigarettes? No☐ Yes☐ How many cigarettes per day? ______________

Females Only: Are you currently pregnant? ________Date of last period**?** ____________

To the best of my knowledge all of the above information on my health history is accurate and true.

______________________ ____________

Patient Signature Date