DR. ALLISON LEGG
CHIROPRACTOR

PERSONAL INFORMATION

TITLE: MR. ☐ MRS. ☐ MISS ☐ MS. ☐ DR. ☐ | DATE

FIRST NAME | INITIAL | LAST NAME | OCCUPATION

ADDRESS | APT # | CITY | PROVINCE | POSTAL CODE

HOME TELEPHONE | BUSINESS TELEPHONE | CELLULAR TELEPHONE | EMAIL ADDRESS

BIRTH DATE DAY/MONTH/YEAR | SEX ☐ MALE ☐ FEMALE | HOW DID YOU HEAR ABOUT US?

IN CASE OF EMERGENCY

CONTACT NAME | TELEPHONE | RELATIONSHIP

MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR? ☐ YES ☐ NO *IF YES, PLEASE COMPLETE THE FOLLOWING:*

DOCTOR'S NAME | DOCTOR'S TELEPHONE NUMBER | LAST VISIT

ADDRESS | SUITE | CITY | PROVINCE | POSTAL CODE

DO YOU HAVE ANY ALLERGIES? | ARE YOU MAKING A CLAIM FOR

1) RECENT MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO
2) WORK RELATED INJURY/ACCIDENT (WSIB) ☐ YES ☐ NO

CHIROPRACTIC INFORMATION

WHAT IS THE REASON FOR SEEKING CHIROPRACTIC CARE TODAY? | HOW LONG HAVE YOU BEEN SUFFERING WITH THIS CONDITION?

HAVE YOU SOUGHT TREATMENT FROM ANY OTHER HEALTH CARE PROFESSIONAL? ☐ YES ☐ NO

TREATMENT RECEIVED

HAVE YOU EVER HAD CHIROPRACTIC CARE IN THE PAST? ☐ YES ☐ NO *IF YES, PLEASE COMPLETE THE FOLLOWING:*

CHIROPRACTOR'S NAME | LAST VISIT

REASON FOR SEEKING CARE

MEDICAL HISTORY (please check at all that apply)

Your History

Fainting	☐	HIV/AIDS	☐	Neurological Disease	☐
Dizziness	☐	Herpes	☐	Other	☐
Loss of Sleep	☐	Athletes Foot	☐	Please specify	
Fatigue	☐	Warts	☐		
Nervousness	☐	Rashes	☐		
Weight Loss	☐	Easily Bruise	☐		
Weight Gain	☐	Boils	☐	**Family History**	
Numbness	☐	High Blood Pressure	☐	Cancer	☐
Tingling	☐	Low Blood Pressure	☐	Stroke	☐
Paralysis	☐	Heart Disease	☐	Diabetes	☐
Headaches	☐	Stroke	☐	Hypertension	☐
Migraines	☐	Varicose Veins	☐		
Palpitations	☐	Swelling	☐	**Lifestyle**	
Epilepsy	☐	Poor Circulation	☐	Smoking	☐
Hepatitis	☐	Bone Disease	☐	Exercise	☐
TB	☐	Arthritis	☐	Healthy Diet	☐

List all surgeries you have had in the past

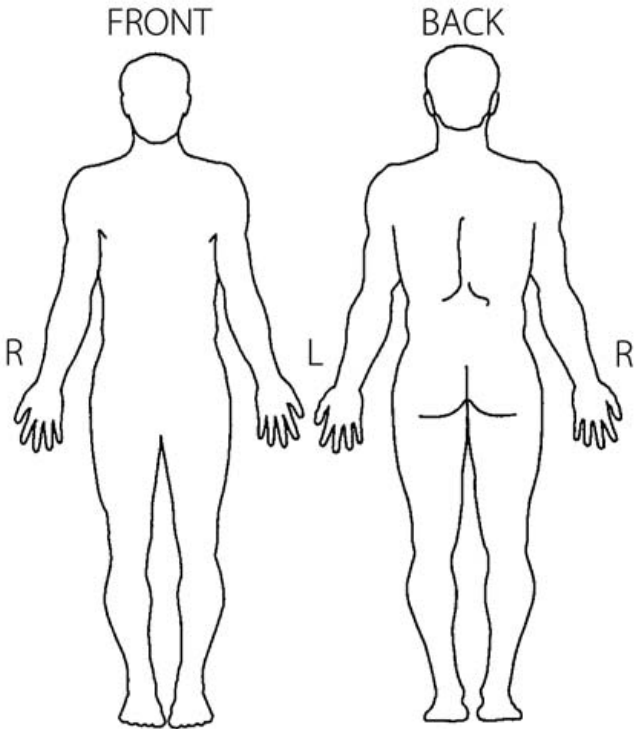
List all prescription/over-the-counter medications and supplements (vitamins/minerals), you are presently taking

Women Only : Are you Pregnant? ☐ Yes ☐ No

Due Date _____

PLEASE TURN OVER

CHIEF COMPLAINT - RANSFORD PAIN DIAGRAM



HOW TO COMPLETE THIS DIAGRAM

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

Ache	Burning	Numbness	Tingling	Stabbing/Sharp	Deep
XXXX	++++++	^^^^^^	*******	//////////	======

How did your symptoms start?

- ☐ sudden
- ☐ gradual
- ☐ car accident
- ☐ work related injury

When did your symptoms start?

- ☐ 0-3 months ago
- ☐ 3-6 months ago
- ☐ 6-9 months ago
- ☐ 1 year or more ago

Please mark on the line below the level of your discomfort.

0 — no pain

10 — worst pain

Dated this _____day of _____, _____.

Patient Signature (Legal Guardian)

Please print name

Signature of Witness

Please print name