Chiromedics

HEALTH CENTRE

Date ______________________________

Personal Information:

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐Miss. ☐ Dr.

____

First Name *Surname*

Address: ____

Street *City/Town* *Postal Code*

Age: _______ Birth Date: _____/_____/_____ Marital Status: ____________________

Phone Number: Home_______________Work ________________Cell:_________________

Can we leave you a message? If yes, please specify at which location: _____________

Employer Name: _________________________ Occupation: _______________________

Physicians Name: ________________________Phone Number: ____________________

Emergency Contact________________________Relationship:_______________________

Phone Number: ____________________________

Health Information

Have you had any previous chiropractic care? ☐ Y ☐ N If yes; reason: __________

____

What seems to make the condition better? ______________________________________

What seems to make the condition worse? ______________________________________

Has the condition; ☐ gotten worse ☐ stayed the same ☐ gotten better

Does the pain radiate/shoot anywhere else? _____________________________________

Have you had this pain before? If yes, when? ____________________________________

Is this a work related injury or an injury resulting from a car accident? Please specify:

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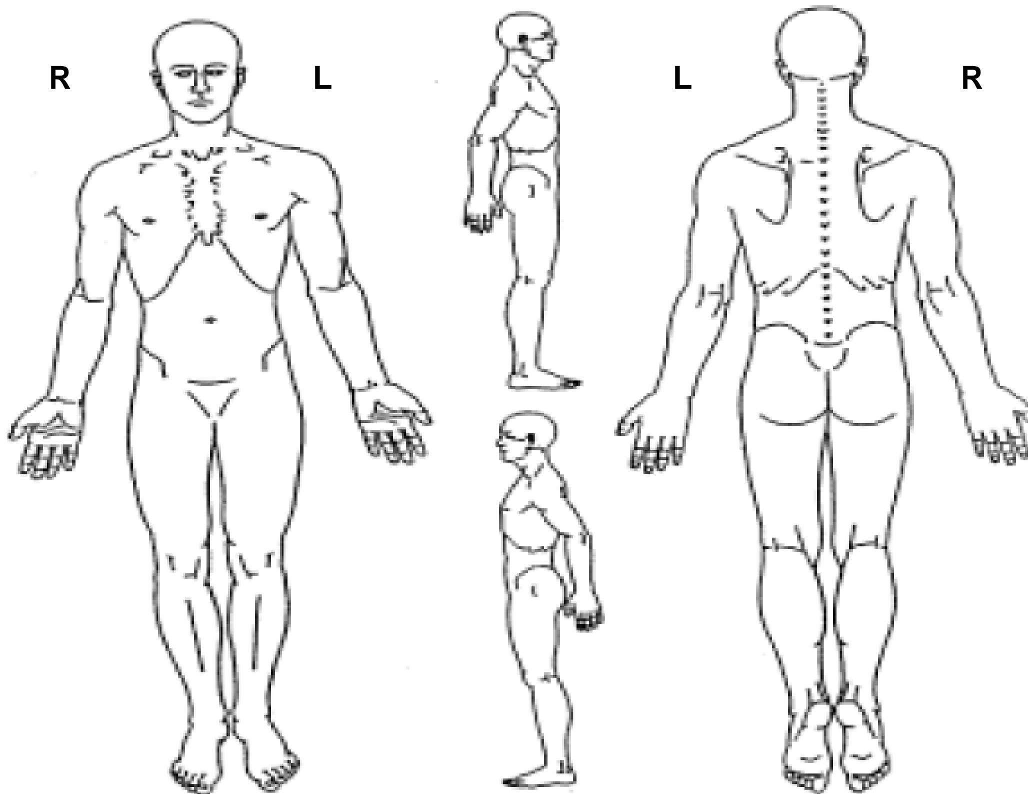
Instructions: *Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.*

//////// Stabbing	OOO Pins and needles	++++ Aching
XXX Burning	- - - - Numbness	



Please circle your current pain level

no pain 0 1 2 3 4 5 6 7 8 9 10 **worst pain imaginable**

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Physical History

Please place an (X) beside any condition you have had or presently have

Musculoskeletal system

___ neck problems
___ upper back problems
___ shoulder problems
___ elbow/wrist problems
___ low back problems
___ knee problems
___ ankle/foot
___ arthritis

Nervous system

___ numbness
___ loss of feeling
___ headaches
___ dizziness
___ fainting
___ confusion
___ depression
___ forgetfulness

Cardio-Vascular-Resp.

___ chest pain
___ high blood pressure
___ difficult breathing
___ persistent cough
___ coughing phlegm/blood
___ lung problems
___ varicose veins
___ diabetes
___ hypoglycemia

Genito-Urinary system

___ painful urination
___ excessive urine
___ scanty urine
___ discolored urine

Female

___ premenstrual syndrome
___ vaginal discharge
___ vaginal bleeding
___ pregnancy
___ breast pain, and/or lumps

Gastrointestinal system

___ poor appetite
___ excessive hunger
___ abdominal pain
___ excessive thirst
___ nausea/vomiting
___ diarrhea
___ constipation
___ bloody/black stool
___ liver/gallbladder trouble
___ weight trouble

Ear, Eyes, Nose, Throat

___ eye problems
___ vision problems
___ ear discharge
___ ear pain
___ ear ringing
___ hearing loss
___ sore throat
___ allergies
___ hoarseness

Are you currently taking any medications (prescription or over the counter): If yes, please note: ______________________________

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Have you ever been in a motor vehicle accident? ☐ Y ☐ N If yes, when: ____________

Family History

Please check if any one of your family members have or have had any of the following, and if so how are you related?

- ☐ Cancer
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Other, please specify: ______________________________________

Social History

Do you smoke? ☐ Y ☐ N If yes, how many packs/day? ____ For how long? _____

Do you consume alcohol? ☐ Y ☐ N If yes, how many drinks/week? ____________

Do you exercise? ☐ Y ☐ N If yes, how many times/week? ____________________

I have stated all conditions that I am aware of and this information is true and accurate. I will inform Chiromedics Health Centre of any changes to my status.

Date: ______________________________

Patient name: _______________________ Patient signature: ____________________

Parent/Guardian:_____________________ Parent/Guardian signature:_____________
(If under 16)

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