Welcome To Our Clinic!

All information we collect is to better serve our patients and is kept strictly confidential.

NW Chiropractic & Massage

PATIENT INFORMATION

Name: _____ **Alberta Health Care Number:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

EMAIL: _____

Date of Birth: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Height: _____ **Weight:** _____ **Marital Status:** _____

Occupation: _____ **Employer:** _____ **Number of Children:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

MEDICAL INFORMATION

Family Doctor's Name: _____ **Clinic Name:** _____

Date of Last MD Visit: _____ **Phone:** _____

Date of Last Physical: _____

What Medications Are You Taking? _____

Which Other Therapies Have You Received:

☐ Chiropractic ☐ Massage ☐ Physiotherapy ☐ Acupuncture ☐ Other _____

HOW DID YOU FIND US?

How did you find our clinic? _____

☐ Referred by Family / Friend ☐ Referred by MD ☐ Internet / Website ☐ Health Care Event

☐ Referred by Trainer ☐ Walk In ☐ Other _____

Whom May We Thank For The Referral? _____

CONDITION OR INJURY INFORMATION

Reason For Your Visit: _____ **When Did This Begin?** _____

Have You Had This Before? ☐ Yes ☐ No **When?** _____

Is It Getting: ☐ Worse ☐ Better ☐ Unchanged

Is This Related To: ☐ Work Injury ☐ Auto Accident ☐ Sport Related ☐ Fall

What Does Your Pain Feel Like? (check all that apply)

☐ Tight and Stiff ☐ Dull / Achy ☐ Sharp ☐ Pins and Needles ☐ Numb ☐ Burning

☐ Other _____

When Do You Feel Pain?

☐ Constant ☐ Intermittent ☐ At Night ☐ First Thing in the Morning ☐ Other _____

What Aggravates Your Pain?

☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Exercise ☐ Weather Change ☐ Rest

☐ Other _____

What Relives Your Pain?

☐ Rest ☐ Movement ☐ Ice ☐ Heat ☐ Medication ☐ Other _____

Have You Seen Anyone Else For This Condition: ☐ Yes ☐ No **Who?** _____

PLEASE RATE YOUR PAIN:

Least Pain **0 1 2 3 4 5 6 7 8 9 10** Most Pain

Does This Condition Interfere with: ☐ **Work** ☐ **Family / Social Life** ☐ **Sport / Hobby** ☐ **Sleep**

What Do You Think Caused This Condition? _____

When Was The Last Time You Felt Healthy? _____

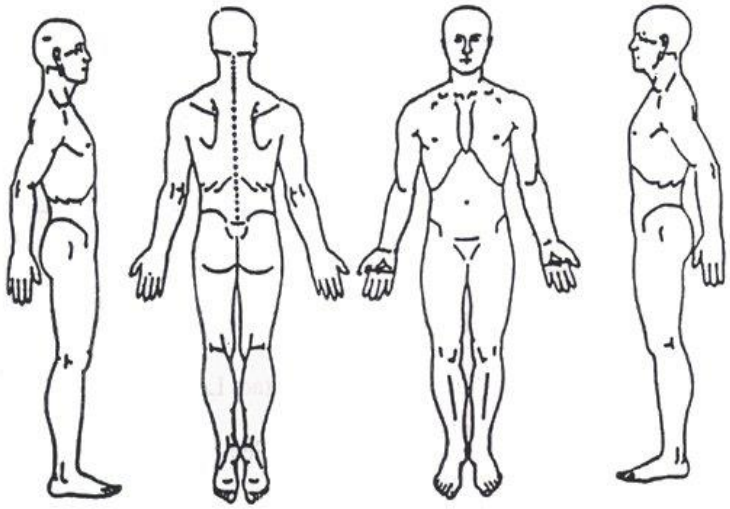
What Is This Condition Stopping You From Doing? _____

Please List Any Secondary Complaints: _____

You Are Committed To: ☐ **Reducing Pain** ☐ **Removing The Cause Of The Problem**

☐ **Changing Lifestyle** ☐ **Stretching / Exercising** ☐ **Taking Supplements**

PLEASE INDICATE ON THE DIAGRAM THE AREAS YOU FEEL PAIN, TENSION, DISCOMFORT



Numbness	≡≡≡≡	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	ΔΔΔΔ	Stiff/Tight	2222

HEALTH HISTORY:

At Any Time In The Past, Have You:

Had Surgery: ☐ **Yes** ☐ **No** **Had a Fracture:** ☐ **Yes** ☐ **No**

Been Hospitalized: ☐ **Yes** ☐ **No** **Been in a Car Accident:** ☐ **Yes** ☐ **No**

Had a Concussion: ☐ **Yes** ☐ **No** **Explain The Above:** (When, Where, Why) _____

Have You Been Diagnosed With:

☐ **Cancer** ☐ **HIV / Aids** ☐ **Hepatitis** ☐ **Other**

☐ **High Blood Pressure:** ☐ **High Cholesterol**

☐ **Are You Pregnant?** **Due Date:** _____ **# Of Previous Pregnancies:** _____

 # Of Children: _____

☐ **Allergies** **Please List:** _____

FAMILY HISTORY:

Is There a Family History Of:	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
Mothers Side:	☐	☐	☐	☐	☐	☐
Fathers Side:	☐	☐	☐	☐	☐	☐

LIFESTYLE:

Are You Currently a Smoker? ☐ Yes ☐No Were You Ever a Smoker? ☐ Yes ☐No

Amount Per Day: _____ When? _____

Do You Consume Alcohol? ☐ Yes ☐No Do You Drink Coffee? ☐ Yes ☐No

Amount Per Day: _____ Amount Per Day: _____

Do You Exercise? ☐ Yes ☐No Rate Your Stress Level:

How Often? _____ ☐Extreme ☐High ☐Moderate ☐Low ☐None

GENERAL HEALTH SURVEY:

Musculo-Skeletal

- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Walking Problem
- ☐ Clicking Jaw
- ☐ TMJ Pain
- ☐ Sciatica
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Gout

Neurological

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Fainting
- ☐ Convulsions
- ☐ Nausea
- ☐ Loss of Balance
- ☐ Cold / Tingling Extremities

Ear/Nose Throat

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Ear Infections
- ☐ Hearing Problems
- ☐ Stuffed Nose
- ☐ Sinus Infections
- ☐ Ringing in Ears

Respiratory

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Lung Problems / Congestion
- ☐ Asthma
- ☐ Coughing up Blood
- ☐ Coughing up Phlegm
- ☐ Chronic Cough

Cardiovascular

- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Chest Pain
- ☐ Previous Heart Attack
- ☐ Previous Stroke
- ☐ Chest Pain

General

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Night Pain
- ☐ Anxiety
- ☐ Depression
- ☐ Fainting
- ☐ Loss of Weight

Genito-Urinary

- ☐ Bladder Problems
- ☐ Painful / Excessive Urination
- ☐ Discoloured Urine
- ☐ Kidney Infection
- ☐ Blood in Urine
- ☐ Menstrual Cramps
- ☐ Kidney Infection
- ☐ Irregular / Absent Cycle
- ☐ Painful Breasts
- ☐ Prostate Problems

Gastro-Intestinal

- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Liver Problems
- ☐ Bloating
- ☐ Heartburn
- ☐ Black / Bloody Stool
- ☐ Colitis
- ☐ IBS
- ☐ Crohn's