Revised: June 2013

ACQUAINTANCE INFORMATION

THE DATA ON THIS CONFIDENTIAL FORM IS ESSENTIAL IF WE ARE TO RENDER THE BEST PROFESSIONAL CARE. WE APPRECIATE YOUR CO-OPERATION IN FILLING IT OUT SO WE WILL HAVE ACCURATE RECORDS. PLEASE PRINT - THANK YOU.

PERSONAL INFORMATION

Date:					
PATIENT'S LAST NAME		FIRST NAME		PRIMARY PHONE	
HOME ADDRESS		CITY/TOWN		POSTAL CODE	
DATE OF BIRTH D/M/Y	AGE	M or F	OCCUPATION	BUSINESS PHONE	
EMPLOYER		BUSINESS ADDRESS			
MARITAL STATUS	NAME OF SPOUSE	OCCUPATION		BUSINESS PHONE	
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?				BY WHOM WERE YOU REFERRED	
NUMBER AND AGES OF CHILDREN					

ALBERTA HEALTH CARE NUMBER

APPOITMENT REMINDER INFO *(FILL OUT F YOU ARE INTERESTED IN RECEIVING APPT REMINDERS)*

Reminder type: ☐ Text ☐ Email

Cell number/email address:______________________________

Cell service Provider: ____________________________________

Would you like to receive a reminder:

☐ Morning of appt ☐ Day before appt

*** Please note these reminders are not a replacement for marking your appointments down, they are a courtesy. Please do not reply to reminders, if you want to change your appointment call the office at 320-7073) ***

CHIROPRACTIC HEALTH INFORMATION

(PLEASE CIRCLE YOUR ANSWER TO EACH QUESTION, IF YES, EXPLAIN)

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? NO YES

WHEN WAS YOUR LAST VISIT? ______________________________

NAME OF CHIROPRACTOR? _______________________________ TOWN/CITY___________________

WHY DID YOU SEEK CARE? ____________________________X-RAYS TAKEN? NO YES

****

MAJOR COMPLAINT

WHERE IS YOUR MAJOR COMPLAINT? ____

DATE OF ONSET: (D) ______(M) _________ (Y) _______

ONSET WAS: SUDDEN / GRADUAL / ASSOCIATED WITH AN EVENT

PLEASE EXPLAIN: ____

HOW LONG HAVE YOU HAD THIS CONDITION? _____MINUTES/HOURS/DAYS/MONTHS/YEARS

HAS THE PROBLEM BEEN: CONSTANT/INTERMITTENT/OCCASIONAL/CYCLICAL

INDICATE THE PRESENT INTENSITY OF THE PAIN BY CIRCLING THE APPROPRIATE NUMBER:

(MILD) 1 2 3 4 5 6 7 8 9 10 (VERY INTENSE)

WHAT DOES THE PAIN FEEL LIKE? DULL/ACHING/BURNING/THROBBING/SHARP

OTHER: _____________________________

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION: _____________________________________

WHAT MAKES IT FEEL BETTER? ____

DOES THIS LIMIT YOUR DAILY ACTIVITIES? YES NO IF SO, WHICH ACTIVITIES ARE AFFECTED

____

HAVE YOU HAD THIS OR A SIMILAR CONDITION IN THE PAST? YES NO WHEN? _________

SECONDARY COMPLAINT (IF APPLICABLE)

WHERE IS YOUR SECONDARY COMPLAINT? ____

DATE OF ONSET: (D)________(M)________(Y)_________

INDICATE THE PRESENT INTENSITY OF THE PAIN BY CIRCLING THE APPROPRIATE NUMBER:

(MILD) 1 2 3 4 5 6 7 8 9 10 (VERY INTENSE)

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? ____________________________________

WHAT MAKES IT FEEL BETTER? ____

HEALTH HISTORY

PLEASE LIST ANY SURGICAL OPERATIONS: ____

AND THE YEARS THEY WERE PERFORMED: ____

NAME OF FAMILY DOCTOR: ____

ARE YOU CURRENTLY TAKING:

BIRTH CONTROL PILLS INSULIN MUSCLE RELAXANTS NERVE PILLS

PAIN KILLERS VITAMINS TRANQUILIZERS

PEP PILLS OTHER MEDICATIONS: ____

ARE YOU PRESENTLY UNDER THE CARE OF A PHYSIOTHERAPIST? NO YES

IF YES, WHO? ________________________________

ARE YOU PRESENTLY SEEING A NATUROPATH OR HOMEOPATHIC DOCTOR? NO YES

IF YES, WHO? ________________________________

ARE YOU PRESENTLY UNDER THE CARE OF A MASSAGE THERAPIST? NO YES

IF YES, WHO? _________________________________

For patients being co-managed within Power Health, please initial here to give your consent for consultation between practitioners regarding the management of your case. _______

DO YOU SMOKE? NO YES IF YES, HOW MANY PER DAY? _____ FOR HOW LONG? _________

HOW DO YOU SLEEP? ON BACK ON SIDE ON STOMACH A COMBINATION

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? NO YES DATE(S):________________

DESCRIBE: ____

HAVE YOU HAD ANY OTHER PERSONAL INJURY? PAST YEAR PAST 5 YEARS OVER 5 YEARS

PLEASE DESCRIBE: ____

INTERESTS/HOBBIES: ____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care. Please indicate if you've had any of the following in your lifetime by checking the appropriate box:

☐ Appendicitis	☐ Malaria	☐ Chicken Pox	☐ Asthma	☐ Rheumatic fever
☐ Scarlet Fever	☐ Tuberculosis	☐ Diabetes	☐ Polio	☐ Mumps
☐ Diphtheria	☐ Whooping Cough	☐ Cancer	☐ Arthritis	☐ Influenza
☐ Typhoid Fever	☐ Anemia	☐ Heart Disease	☐ Epilepsy	☐ Small Pox
☐ Pneumonia	☐ Measles	☐ Goiter	☐ Psychological Disorders	

IN YOUR FAMILY, IS THERE A HISTORY OF SERIOUS DISEASE? EXPLAIN: ______________________________

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING YOU **HAVE** OR **HAVE HAD** IN THE PAST 6 MONTHS:

MUSCLO-SKELETAL CODE:

☐ Ankle Pain
☐ Knee Pain
☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Shoulder Pain
☐ Wrist Pain
☐ Elbow Pain
☐ Difficult/ Chewing/Clicking Jaw

NERVOUS SYSTEM CODE

☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion
☐ Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Extremities

GENERAL CODE

☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches

GASTRO-INTESTINAL CODE

☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Trouble
☐ Gall Bladder Problems
☐ Weight Changes
☐ Abdominal Cramps
☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

GENITO-URINARY CODE

☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discoloured Urine

C-V-R CODE

☐ Chest Pain
☐ Short Breath
☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling

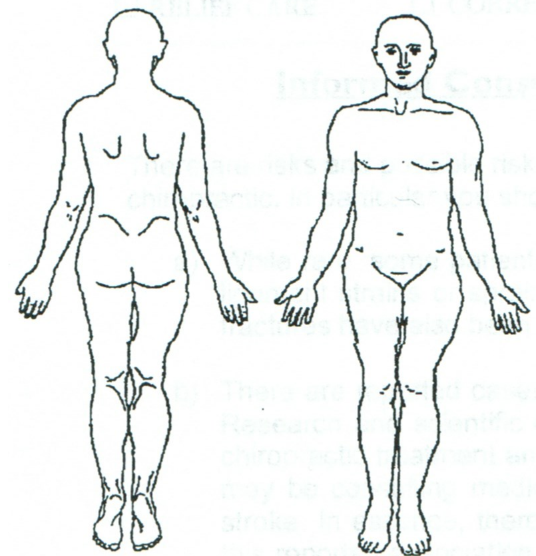
EENT CODE

☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

MALE/FEMALE CODE

☐ Menstrual Irregularity
☐ Menstrual Cramping
☐ Vaginal Pain/Infections
☐ Breast Pain/Lumps
☐ Prostate/Sexual Dysfunction
☐ Genital Herpes

Please outline in the diagram the area of your discomfort:



FEMALES ONLY:
When was your last period? ___________________
Are you pregnant? ☐ YES ☐ NO ☐ MAYBE