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	HEIGHT / WEIGHT
OCCUPATION	EMPLOYER		BUSINESS ADDRESS & PHONE
ALBERTA HEALTH CARE NUMBER			
MARITAL STATUS	NAME OF SPOUSE	OCCUPATION	BUSINESS PHONE
NUMBER AND AGES OF CHILDREN			BY WHOM WERE YOU REFERRED
NAME OF EMERGENCY CONTACT & NUMBER			RELATIONSHIP

APPOINTMENT REMINDER INFO *(FILL OUT IF YOU ARE INTERESTED IN RECEIVING APT. REMINDERS)*

Reminder type: ☐ Text ☐ Email ☐ Calendar attachment (for smartphones)

Cell number/email address:_____

Cell service Provider: _____

Would you like to receive a reminder:

☐ Morning of apt. ☐ Day before apt.

*** 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: _____

IS THIS A WORK RELATED INJURY? YES NO

IF YES, HAS YOUR EMPLOYER BEEN NOTIFIED? YES NO

IS THIS A MOTOR VEHICLE ACCIDENT? YES NO IF YES, DATE:_____

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

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

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 XRAYS, MRI, OR OTHER TEST FOR THIS CONDITION? YES NO

IF YES, EXPLAIN: _____

HAVE YOU SEEN OTHER PRACTIONERS FOR THIS CONDITIONS? YES NO

IF YES, EXPAIN: _____

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)

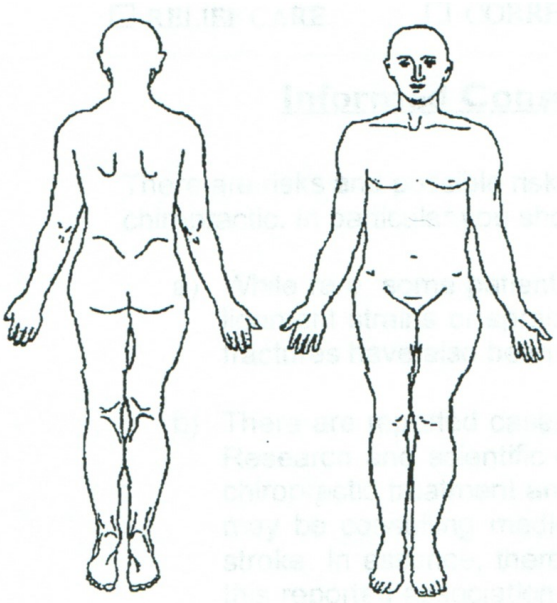
WHAT DOES THE PAIN FEEL LIKE? DULL/ACHING/BURNING/THROBBING/SHARP

OTHER: _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT MAKES IT FEEL BETTER? _____

Please outline in the diagram the area of your discomfort:



HEALTH HISTORY

PLEASE LIST ANY SURGICAL OPERATIONS & THE YEARS THEY WERE PERFORMED?_____

_____

NAME OF FAMILY DOCTOR: _____

LIST ALL MEDICATIONS, OVER THE COUNTER & PRESCRIPTIONS, SUPPLEMENTS, VITAMINS, HERBAL SUPPORTS, ASPIRIN, ETC.:_____

_____

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: _____

_____

Cont'd 

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.

UNDERLINE ANY CONDITIONS THAT ARE **PRESENTLY** CAUSING YOU A PROBLEM, **CHECK** ANY CONDITIONS WITHIN THE **LAST 6 MONTHS**:

GENERAL SYMPTOMS

- ☐ Fever
- ☐ Sweats
- ☐ Fainting
- ☐ Sleep Disturbance
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight Loss
- ☐ Weight Gain

RESPIRATORY

- ☐ Chronic Cough
- ☐ Spitting Up Phlegm
- ☐ Spitting Up Blood
- ☐ Chest Pain
- ☐ Wheezing
- ☐ Difficulty Breathing
- ☐ Asthma

GENITOURINARY

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood In Urine
- ☐ Pus In Urine
- ☐ Kidney Infection
- ☐ Prostate Trouble
- ☐ Uncontrollable Urine Flow

NEUROLOGICAL

- ☐ Visual Disturbance
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions
- ☐ Headache
- ☐ Numbness
- ☐ Neuralgia (Nerve Pain)
- ☐ Poor Coordination
- ☐ Weakness

CARDIOVASCULAR

- ☐ Rapid Beating Heart
- ☐ Slow Beating Heart
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pain Over Heart
- ☐ Hardening Of Arteries
- ☐ Swollen Ankles
- ☐ Poor Circulation
- ☐ Palpitation
- ☐ Cold Hand or Feet
- ☐ Varicose Veins

GASTROINTESTINAL

- ☐ Poor Appetite
- ☐ Difficult Digestion
- ☐ Heartburn
- ☐ Ulcers
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood In Stool
- ☐ Gallbladder/Jaundice
- ☐ Colitis

EYES, EARS, NOSE, THROAT

- ☐ Eye Pain
- ☐ Double Vision
- ☐ Ringing In Ears
- ☐ Deafness
- ☐ Nosebleeds
- ☐ Trouble Swallowing
- ☐ Hoarseness
- ☐ Sinus Infection
- ☐ Nasal Drainage
- ☐ Enlarged Glands

MUSCLE & JOINT

- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Elbow Pain
- ☐ Hand Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Foot/Ankle Pain
- ☐ Pain/Numbness Down Arms or Legs
- ☐ Swollen Joints
- ☐ Spinal Curvature
- ☐ Arthritis
- ☐ Fractures
- ☐ Difficult Chewing/Clicking Jaw

FOR WOMEN ONLY

- ☐ Painful Menstruation
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Cramps Or Back Pain
- ☐ Vaginal Discharge
- ☐ Nipple Discharge
- ☐ Lumps In Breast
- ☐ Menopausal Symptoms
- ☐ Birth Control Pills
- ☐ Miscarriages
- ☐ Complications With Pregnancy
- ☐ Pregnant? Y / N Week?
- ☐ Other: