

CONFIDENTIAL PATIENT INTRODUCTION



Name: _____ Date: _____
Address: _____ City: _____
Province: _____ Postal Code: _____
Phone: (H) _____ (W) _____ (C) _____
Date of Birth: _____ Age: _____ Occupation: _____
Marital Status: _____ No. of Children: _____ Referred by: _____
Email Address: _____
Medical Doctor: _____ Phone #: _____
Do we have permission to inform your M.D. of your diagnosis and treatment? Y N

Reason for consulting our office: _____

How long have you had this condition? _____

How are these systems affecting your quality of life? _____

What aggravates this condition? _____

What makes it feel better? _____

Is it getting: Worse Constant Comes&Goes Better
Previous diagnosis and treatment for present condition: _____

Other Complaints: _____

List any surgery, accidents, falls: _____

Are you on any drugs? Anti-Inflammatories Pain Killers Muscle Relaxants
Antidepressants Other: _____

Have you ever had previous Chiropractic care? Yes No
If yes, when? _____ with Dr. _____

FAMILY HEALTH INFORMATION: Many health problems are the result of *hereditary spinal weaknesses*. This information about your family members will give us a better picture of your total health. Please list any member of your family who has any kind of health problem, including your children:

Name	Relation	Past and Present Health Problems
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

NUTRITIONAL:

Meals per day: _____
Are you satisfied with your nutritional status and diet? Yes No
Do you take a multivitamin? Yes No
Do you exercise regularly? Yes No Cardio? Yes No Weights? Yes No

PSYCHOSOCIAL: Have any of the following occurred recently?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Divorce | <input type="checkbox"/> Drugs/alcohol increase | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Death | <input type="checkbox"/> Change in job status | <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Family problems |
| <input type="checkbox"/> Increased work stress | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Economic stress | <input type="checkbox"/> Other: _____ |

CHECK THE CONDITIONS FOR WHICH YOU HAVE BEEN TREATED:

- | | | | |
|---------------------------------------|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> HIV/AIDS | | | |

HAVE YOU EVER:

- | | | |
|--|------------------------------|-----------------------------|
| Been knocked unconscious | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Used a cane, crutch, or other support | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been treated for spine or nerve disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had a fractured bone | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been hospitalized for other than surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

DATE OF LAST:	Less than 12 mos.	Over 12 mos.	List the conditions for which you have been treated in the last 10 years:
Spinal examination	_____	_____	_____
Physical examination	_____	_____	_____
Blood test	_____	_____	_____
Chest x-ray	_____	_____	_____
Spinal x-ray	_____	_____	_____
Dental x-ray	_____	_____	_____
Urine test	_____	_____	_____

FOR WOMEN ONLY:

When was your last period? _____ Are you pregnant? Yes No Maybe

What are your health goals? _____

There are different approaches to health care. I am most interested in:

- () Relieving my symptoms only
- () Fixing this problem, and making sure it does not return
- () Correcting the cause of this problem and any others I may have
- () Wellness care – achieving and maintaining good health and well-being

I understand and agree that health and accident insurance policies are in arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment to the chiropractic clinic.

Signature

Date