

Second Avenue Family Chiropractic Centre

CONFIDENTIAL PATIENT HISTORY

Please complete this questionnaire. Your answers will help us determine if chiropractic/massage can help you. If we do not sincerely believe your condition will respond satisfactorily, we will refer your case. All information will be considered confidential.

Name _____ Birth D ___ / M ___ / Y ___ Age _____
Address _____ City _____ Postal Code _____
Telephone: Home _____ Work _____ Cell _____
Occupation _____ Health Card # _____ Sex: M F
Emergency Contact Name _____ Phone Number _____
Medical Doctor _____ Referred by: _____

Do any of these coverages relate to you?

WCB ___ Injury Date _____ SGI ___ Injury Date _____ RCMP ___ DVA ___
Supplementary Health Benefits ___ Family Health Benefits ___ Other: _____

1. What is your reason for consulting this office? _____
2. How long have you had this condition? _____
3. What is your problem preventing you from doing? _____
4. What have you tried that has not worked? _____
5. Have you had other tests performed (x-ray, lab work i.e. blood/urine)? Yes _____ No _____
When? _____ Where? _____ Why? _____
6. Any work injuries or car accidents within ___ past year ___ past 5 years ___ over 5 years
Describe: _____
7. Do you sleep well? Yes _____ No _____
Back _____ Left/Right Side _____ Stomach _____ Restless _____
8. Are you taking any medications or supplements (including Tylenol, Advil or Vitamins)?
No ___ Yes ___ What/How much _____
9. Any major surgery? Yes _____ No _____ Describe: _____
10. Any serious illness? Yes _____ No _____ Describe: _____

Have you recently had problems with the following: (Please circle)

Dizziness	Heart Trouble	Cancer	Headaches
Back Pain	Arthritis	Sinus Trouble	Depression/Anxiety
Digestive Disorders	Neck Pain	Asthma	Bowel/Bladder/Menstrual
Diabetes	Epilepsy	Strokes	HIV
High Blood Pressure	Other: _____		None of the above

Mark the areas on the diagram where you feel the described sensations.

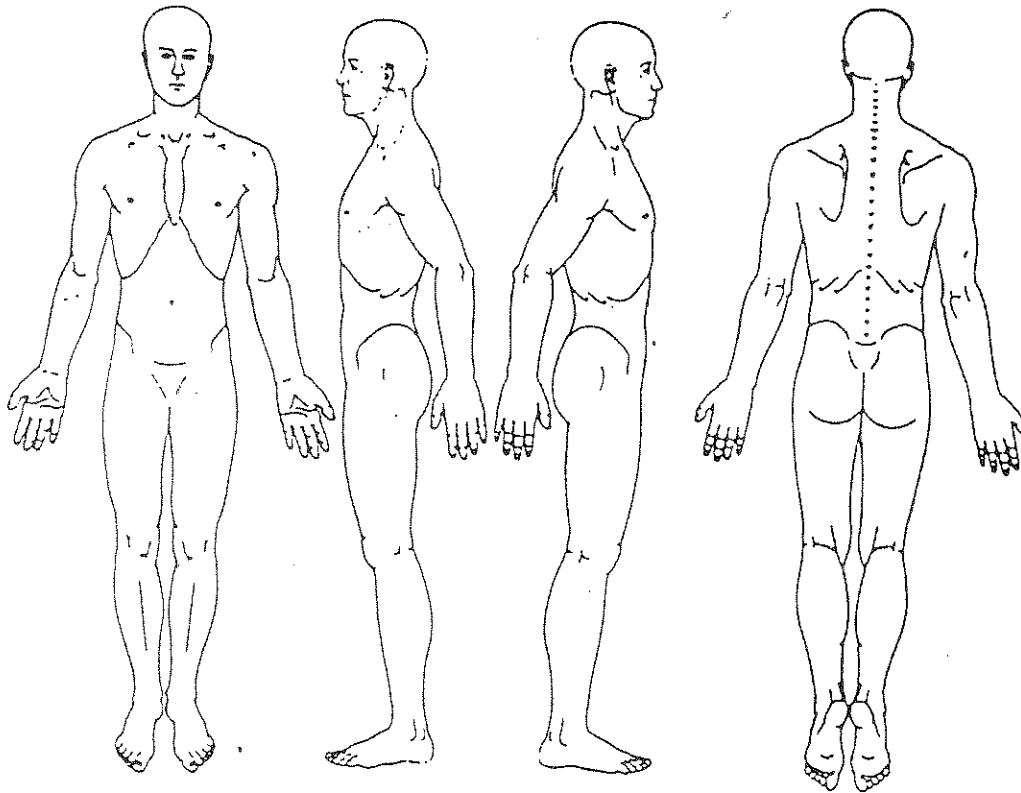
Use the appropriate symbols. Include all affected areas.

Dull/achy +++++ Burning xxxxx Pins and Needles ooooo

Numbness ///// Sharp ^^^^^

Left

Right



Please rate your pain level by making a mark on the line below

NO PAIN (_____) PAIN AS BAD AS
 1 2 3 4 5 6 7 8 9 10 IT COULD BE

Personal Habits:

Alcohol Servings/Week	7+ _____	4-6 _____	1-3 _____	0 _____
Coffee/Tea/Soft Drinks/Day	4-5 _____	2-3 _____	1 _____	0 _____
Tobacco/Day (packages)	1 _____	3/4 _____	1/2 _____	0 _____
Exercise	4-7x/wk _____	3x/wk _____	1-2x/wk _____	0 _____

Type of exercise: _____

 Patients Signature

 Date