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: Day _____ **Work** _____ **Evening** _____

Email_____ **Occupation** _____ **Sex: M F**

Health Card # _____ **Pregnant: Y how far along** _____ **N**

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 skin conditions/allergies? Yes ____ No ____ Describe: _____
10. Any major surgery? Yes _____ No _____ Describe: _____
11. Any serious illness? Yes _____ No _____ Describe: _____

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

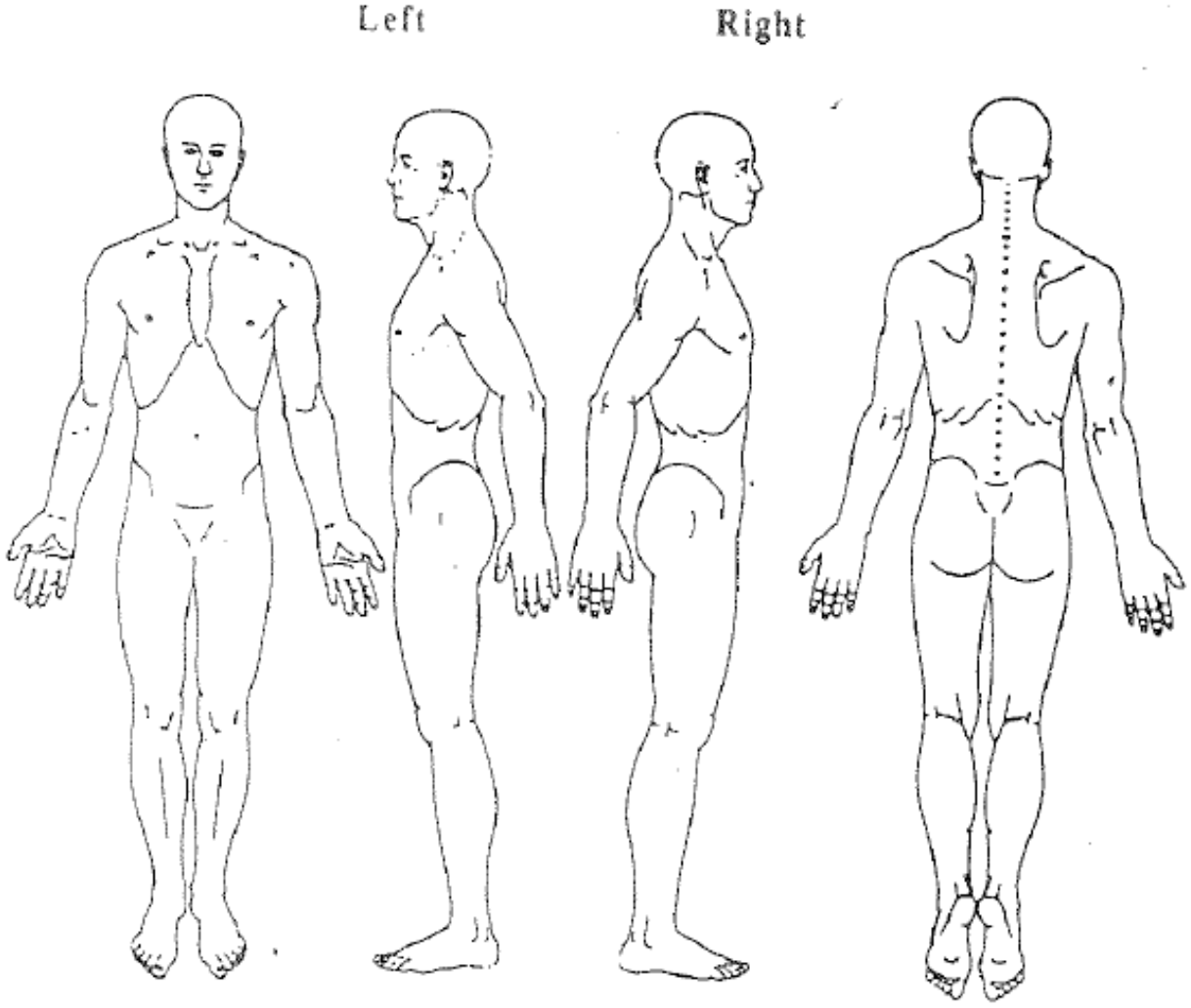
Dizziness	Heart Trouble	Cancer	Headaches
Back Pain	Arthritis	Sinus Trouble	Depression/Anxiety
Digestive Disorders	Neck Pain	Asthma	Bowel/Bladder/Menstrual
Diabetes	Epilepsy	Strokes	HIV
High Blood Pressure	Other: _____		***None of the above***

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 **^^^^^**



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

NO PAIN (_____**)** **PAIN AS BAD AS IT COULD BE**

1 2 3 4 5 6 7 8 9 10

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 ____	¾ ____	½ ____	0 ____
Exercise	4-7x/wk ____	3x/wk ____	1-2x/wk ___	0 ____

Type of exercise: _____

_____ _____

Patients Signature Date