Broker's Active Care Klinic
Chiropractic, Massage, Health & Fitness Centre
3350 2nd Avenue West Prince Albert, SKS6V 5E9
(306) 922-7028 ph (306) 953-9841 fax www.backlinic.com

Name: ____________________________ Date: __________________________

Health #: __________________________ DOB: ___________ Sex: M F

Patient #: __________________________ Doctor: __________________________

Acupuncture Confidential Patient History

Please complete this questionnaire. Your answers will help us determine if acupuncture can help you. If we do not sincerely believe your conditions will respond satisfactory, we will refer your case. All information will be considered confidential

Name:___________________________ DOB ___/___/___ Age:____
Mo Day Yr

Address: ____

City/Town:______________________________ Prov:_______ Postal Code: __________________

Telephone: (hm) ____________________ (wk) ___________________ (cell) __________________

Occupation: ___________________________ Employer: ____________________________________

Contact Name: ___________________________ Contact Number _____________________________

Medical Doctor:___________________________

Health Information

1. What is your major complaint? ____
2. How long have you had this condition? ____
3. What do you feel brought on this condition? ____
4. Did this happen at work? Yes______ No _______ Date of injury: ________________
5. Have you had this or similar conditions in the past? ____
6. Have you had previous Acupuncture treatments? ____
7. Have you seen any other Doctors for this condition? Yes_______________________ No_________
8. Have you had other tests performed? (x-ray, lab work i.e. blood/urine)? Yes ______ No _______
   Where?_________________________ When? _________________________
9. History of seizures? Yes_______ No________ Fainting? Yes ______ No _______
10. Do you have any allergies? Yes _____ No _____ if yes state: ___________________________________
11. Do you have any infections? Yes _____ No _____ if yes state: __________________________________
12. Any personal injuries or car accidents within past year ____ past 5 yrs _____ over 5 yrs _____
    Describe: ____
13. Any serious illness? Yes ____ No____ Describe: ____
14. Any surgeries? Yes ____ No____ Describe: ____
15. Are you on any Drugs or Medications? Yes ____ No____ Describe: ______________________________
16. Do you have a pacemaker? Yes ______ No _______
17. Do you have a prosthetic heart valve? Yes _______ No _______
18. Are you pregnant? Yes _______ No _______

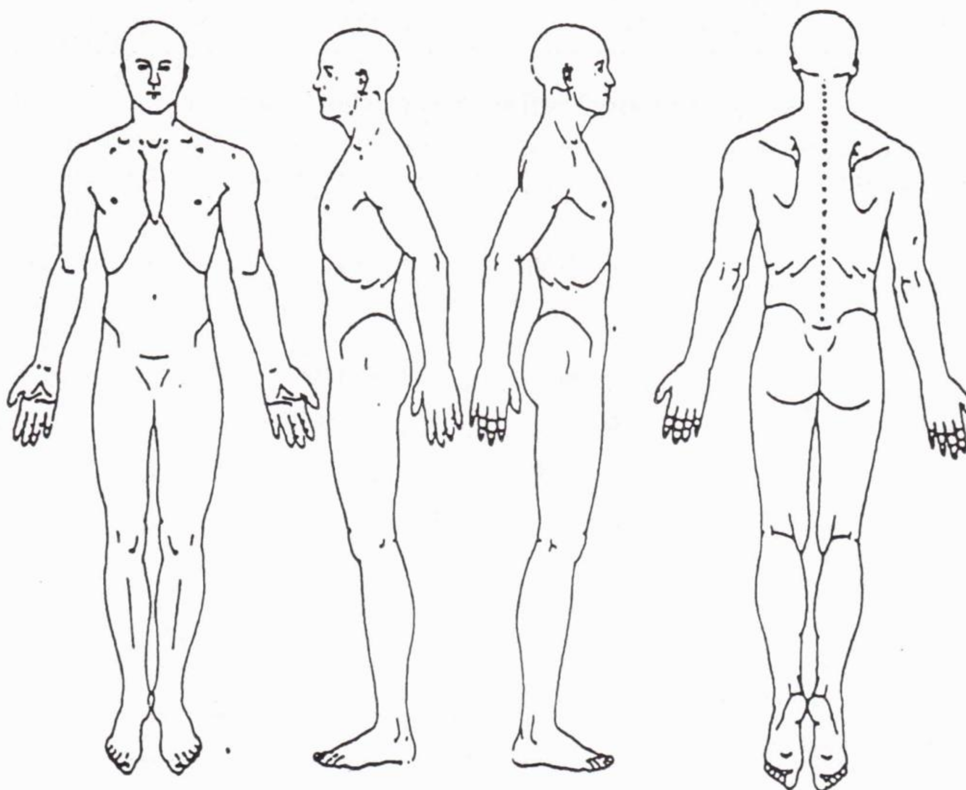
Please Turn Over ➜

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

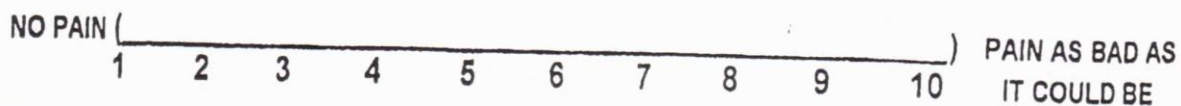
Use the appropriate symbols. Include all affected areas.

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

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



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



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: ______________________________

atients Signature ______________________ Date ______________________