Confidential Patient History
All information is confidential

Name: _____ Date: _____

Health Card # _____ DOB: _____ Sex: M F

Patient # _____ Doctor: _____

SGI: _____ WCB: _____ Other: _____

Name: _____ DOB _____ / _____ /_____ Age: _____
Month Day Year

Address: _____

City/Town: _____ Prov: _____ Postal Code: _____

Telephone:(home) _____(work) _____(cell)_____

Occupation: _____ Employer: _____

(If Student – School): _____ Email: _____

Emergency Contact:_____ Cell#:_____ Relationship:_____

Health Information:

1. What is your major complaint? _____

_____

2. Please rate your pain level by marking a "X" on the pain scale below:

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

1 2 3 4 5 6 7 8 9 10

3. How long have you had this condition? _____

4. If known, state how this injury occurred: _____

5. Have you had this condition in the past? □ Yes □ No Details: _____

6. Medical Doctor: _____

7. Have you seen any other physicians/therapists for this condition? □ Yes □ No

Whom? _____

8. Have you had previous chiropractic care? □ Yes □ No By whom? _____

9. What is your approximate weight? _____ height? _____

10. Referred to this clinic by: _____

11. Is this condition: □ Job related/WCB □ Auto related/SGI Date of Injury: _____

PLEASE TURN OVER →

12. Have you had a x-ray, CT scan, MRI, or U/S for this condition? □ Yes □ No

    If so, When? _____ and Where? _____

13. Present health other than the previously listed complaints: _____

    _____

14. Please list the following in order, with most recent date first, with approximate dates:

    a) Surgeries _____

    b) Broken bones, dislocations _____

    c) Serious illness _____

15. Are you taking any medications? □ Yes □ No If yes, please list medications/conditions:

    _____

Blood Pressure Pills	Anti-inflammatory	Gabapentin	Anti-depressants
Blood Thinners	Pain Killer	Medical Marijuana	Sedatives
Heart Medication	Muscle Relaxant	Birth Control	Insulin

16. Do you have any other spinal problems? □ Yes □ No Describe: _____

    _____

17. Exercise pattern other than work: _____

18. Are you a smoker? □ Yes □ No

19. Do you have any additional comments you feel may benefit the doctor regarding your present condition or general health?: _____

Are you having Acupuncture today? Please answer the following questions:

1. Do you have a history of seizures? Yes _____ No _____
2. Do you have any allergies? Yes _____ No _____ If yes, please state _____
3. Do you have any infections? Yes _____ No _____ If yes, please state_____
4. Any serious illness? Yes _____ No _____ If yes, please state _____
5. Do you have a pacemaker? Yes _____ No _____
6. Do you have a prosthetic heart valve? Yes _____ No _____
7. Are you pregnant? Yes _____ No _____

Signature of patient: _____

Signature of Parent/Guardian if under 16: _____