Chart #__________________
Date__________________

CHIROPRACTIC PATIENT HEALTH HISTORY

Last Name__________________________________ First Name_______________________________ ☐ Male ☐ Female

Address____ City_____________________ Province ______

Postal Code_______________ Home Phone____________________________ Cell Phone________________________

Birth Date (DD/MM/YYYY)____________________ Alberta Health Care Number_______________________________

May we contact you via e-mail? All contact information is kept confidential and we only send about 1 e-mail/month.

☐ Yes, e-mail address____ ☐ No, thanks.

How did you hear about us?____

Purpose of this appointment____

Is this condition: ☐ Job related ☐ WCB Claim ☐ Auto related ☐ Other

List of therapies tried for this condition____

List all medications you currently take____

Surgery/operations____

Major accidents/falls____ Broken bones_________________________

Hospitalizations____

Previous chiropractor_________________________________ Family doctor____________________________________

Have you any other health concerns that you have not had satisfactory help with?_______________________________

Please check any of the following diseases you have had:

☐ Heart disease ☐ Epilepsy ☐ Pneumonia ☐ Rheumatic fever ☐ Arthritis

☐ Anemia ☐ Pleurisy ☐ Eczema ☐ Goiter ☐ Cancer

Please check your current or past (last 6 months) symptoms:

Neck
☐ Headaches
☐ Neck pain
☐ Arm pain/numbness
☐ Joint pain/stiffness
☐ Jaw/TMJ pain
☐ Sinus troubles
☐ Bleeding nose
☐ Loss of concentration
☐ Ear infections

Mid Back
☐ Pain between shoulders
☐ Asthma
☐ High blood pressure
☐ Bronchitis/pneumonia
☐ Gall bladder problems
☐ Heartburn/indigestion
☐ Low energy/chronic fatigue

Low back
☐ Constipation
☐ Diarrhea
☐ Menstrual irregularity
☐ Menstrual cramping
☐ Increased bladder frequency
☐ Prostate problems
☐ Leg pain/numbness
☐ Cold feet

This clinic operates on fee for service; therefore, payment is required at the end of each visit unless I, the patient, choose one of the alternative payment plans. I understand that I am responsible for the fees I incur at this clinic.

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Patient signature