# CONFIDENTIAL PATIENT INTRODUCTION

**Name:** _____ Gender: M F X **Date**: _____

Address: _____ ___ City: _____ Postal Code: _____

Home Telephone: _____ Cell: _____ Work: _____ ext: _____

Date of Birth: _____ Marital Status _____ Number of Children: _____

Occupation: _____ **Health Card Number**: _____

Referred By: _____ Email Address:_____

Have you ever had previous Chiropractic Care? NO YES - When? _____ Name of Chiropractic Dr_____

Name of **Medical Doctor**: _____ Phone: _____ Address: _____

Major Concern: _____

Other Concerns: _____

How long as have you had this condition? _____

What aggravates this condition? _____

Is it getting: Worse_____ Constant_____ Comes/Goes _____ Better _____

Previous diagnose and treatment for present condition: _____

List surgery, accidents, falls: _____

Are you on any medications? NO YES If yes – what are you taking? _____

For what condition? _____

Do you smoke? NO YES

**Family Health Information:** Many health problems are the result of hereditary weaknesses. This information about your family members will give us a better picture of your total health. Please list any member of your family who has any health problem.

| Name | Relation | Past and Present Health Problems |
|---|---|---|
| | | |
| | | |
| | | |

**Psychosocial:**

Have any of the following occurred recently:

- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Disturbances
- ☐ Chronic Fatigue
- ☐ Divorce
- ☐ Death
- ☐ Family Problems
- ☐ Economic Stress
- ☐ Drugs/Alcohol
- ☐ Change in job status
- ☐ Increased work stress
- ☐ Other_____

**Check the Conditions for which you have been treated:**

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever Blisters
- ☐ Mumps
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Ulcers
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Venereal Disease

| **Have You Ever:** | | | **Date of Last:** | Less than 12 months | Over 12 Months |
|---|---|---|---|---|---|
| Been knocked unconscious? | ☐YES | ☐NO | Spinal Examination | _____ | _____ |
| Used a cane, crutch or other support? | ☐YES | ☐NO | Physical Examination | _____ | _____ |
| Been treated for spine or nerve disorder? | ☐YES | ☐NO | Blood Test | _____ | _____ |
| Had a fractured bone? | ☐YES | ☐NO | Chest X-ray | _____ | _____ |
| Been hospitalized for other than surgery? | ☐YES | ☐NO | Spinal X-ray | _____ | _____ |
| | | | Dental X-ray | _____ | _____ |
| | | | Urine Test | _____ | _____ |

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SIGNATURE: _____