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**: _____S.I.N. #_____

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: _____