CAUSES OF SPINAL / NERVE PROBLEMS (SUBLUXATION)

A. EMOTIONAL STRESS: Circle One

	High	med	low
Business	3	2	1
Social	3	2	1
Family	3	2	1

A _____
Total

B. CHEMICAL STRESS:

- ❑ *Environment (i.e. Pollution)*
- ❑ *Smoker - Amount?*
- ❑ *Second-hand Smoke*
- ❑ *Poor Diet*
- ❑ *Caffeine - Amount?*
- ❑ *Excessive Sugar*
- ❑ *Artificial Sweeteners*
- ❑ *Prescription Drugs / Specify*

_____

- ❑ *Over-The-Counter Drugs / (Example: Tylenol; Advil)*

_____

B _____
Total

C. PHYSICAL STRESS:

- ❑ *Birth Traumas (as a mother or child)*
- ❑ *Slips/Falls*
- ❑ *Car Accidents*
- ❑ *Knocked unconscious*
- ❑ *Sports Injuries*
- ❑ *Poor Posture*
- ❑ *Sitting on your wallet*
- ❑ *Sleeping Position - Stomach*
- ❑ *Extensive Computer Work*
- ❑ *Carrying Heavy Purse/Bookbag/Child*
- ❑ *Repetitive Lifting / Bending*
- ❑ *Continuous Hours Sitting/Standing*
- ❑ *Bone Fracture/Surgery*

C _____
Total

TOTAL STRESS: _____
(add A, B and C)

Are you currently on a program of
a) vitamins b) minerals c) herbs d) diet e) exercise f) others?

What is your estimation of your present general health?	***Good***	***Fair***	***Poor***
Are you frequently ill?	***Yes***		***No***
Do you often feel exhausted?	***Yes***		***No***
Do you have trouble sleeping?	***Yes***		***No***
Do you have any allergies (to food, cat's fur, dust, etc.)?	***Yes***		***No***
Do you consider yourself to be a nervous person?	***Yes***		***No***
Are you worried about receiving chiropractic treatment?	***Yes***		***No***

Please inform your doctor if your health changes in any way.

NEW PATIENT FORM

The information you provide is for the confidential use of this office and will only be released with your written consent or if your treatment is covered under Worker's Compensation.

Patient Name: _____ ***Date:*** _____
Home Address: _____ ***Phone#*** _____
City: _____ ***Postal Code:*** _____
Occupation: _____ ***Bus. Phone#*** _____
Email: _____ *(For Appointment Reminders)*
Birth Date: _____ *Age:* _____ *Sex: M* ___ *F* ___ *Status: S* ___ *M* ___
Name of Spouse: _____ *Number of Children:* _____
AHC# _____
Do you have other insurance coverage?: Y ___ *N* ___
Do you want to receive Clinic Newsletters via email?: Y ___ *N* ___
Motor Vehicle Accident: Y ___ *N* ___ *Worker's Compensation Board: Y* ___ *N* ___
Referred By: _____
Emergency Contact: _____
Previous Chiropractic Doctor: _____ *Address:* _____
Medical Doctor: _____ *Address:* _____

REASON FOR CONSULTING THIS CLINIC:

Why chiropractic? People go to chiropractors for a variety of reasons. Some are interested in getting to the cause of their problems and promoting more complete healing. Muscle and soft tissue injuries can remain even without pain, so the goal is to strengthen and stabilize the body to avoid a relapse (corrective care). More and more people, however, are looking to improve their overall health and wellness. They see chiropractors for preventive checkups and programs on how to optimize their health (wellness/maintenance care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible. Check more than one box if applicable.

- ❑ ***Pain Relief Only***
- ❑ ***Corrective Care (avoids a relapse)***
- ❑ ***Maintenance / Wellness Care***
  (A proactive approach to health that helps you continue feeling well)

What is your major concern? _____
How long have you had this condition(s)? _____
Have you had this similar condition in the past? _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? Y ___ *N* ___ *Constant* ___ *Comes and Goes* ___
Is this condition interfering with your work ___ *Sleep* ___ *Daily Routine* ___ *Other?* _____
How long has it been since you really felt good? _____
Others who have treated this condition: _____
In the past year, have x-rays been taken? No ___ *Yes* ___
If yes, where? _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS

MUSCULO-SKELETAL CODE

- ❑ *Low Back Pain*
- ❑ *Pain Between Shoulders*
- ❑ *Neck Pain*
- ❑ *Arm Pain*
- ❑ *Joint Pain/Stiffness*
- ❑ *Walking Problems*
- ❑ *Difficult Chewing/Clicking Jaw*
- ❑ *General Stiffness*

NERVOUS SYSTEM CODE

- ❑ *Numbness*
- ❑ *Headaches*
- ❑ *Dizziness*
- ❑ *Forgetfulness*
- ❑ *Confusion/Depression*
- ❑ *Fainting*
- ❑ *Convulsions*
- ❑ *Cold/Tingling Extremities*

- ❑ *Recent Surgery*
- ❑ *Wear Pacemaker*

GASTRO-INTESTINAL CODE

- ❑ *Poor/Excessive Appetite*
- ❑ *Excessive Thirst*
- ❑ *Frequent Nausea*
- ❑ *Vomiting*
- ❑ *Diarrhea*
- ❑ *Constipation*
- ❑ *Hemorrhoids*
- ❑ *Liver Problems*
- ❑ *Gall Bladder Problems*
- ❑ *Weight Trouble*
- ❑ *Abdominal Cramps*

MALE/FEMALE CODE

- ❑ *Menstrual Irregularity*
- ❑ *Menstrual Cramps*
- ❑ *Vaginal Pain/Lumps*
- ❑ *Prostate/Sexual Dysfunction*
- ❑ *Other Problems*

GENITO-URINARY CODE

- ❑ *Bladder Trouble*
- ❑ *Painful/Excessive Urination*
- ❑ *Discoloured Urine*
- ❑ *Gas/Bloating After Meals*
- ❑ *Heartburn*
- ❑ *Black/Bloody Stool*
- ❑ *Colitis*

C-V-D CODE

- ❑ *Chest Pain*
- ❑ *Short Breath*
- ❑ *Blood Pressure Problems*
- ❑ *Heart Problems*
- ❑ *Lung Problems*
- ❑ *Varicose Veins*
- ❑ *Ankle Swelling*
- ❑ *Stroke*

EENT CODE

- ❑ *Vision Problems*
- ❑ *Dental Problems*
- ❑ *Sore Throat*
- ❑ *Ear Aches*
- ❑ *Hearing Difficulty*
- ❑ *Stuffed Nose (Sinuses)*

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ❑ ***Pneumonia***
- ❑ ***Rheumatic Fever***
- ❑ ***Polio***
- ❑ ***Tuberculosis***
- ❑ ***Anemia***
- ❑ ***Measles***
- ❑ ***Mumps***
- ❑ ***Chicken Pox***
- ❑ ***Diabetes***
- ❑ ***Cancer***
- ❑ ***Heart Disease***
- ❑ ***Thyroid***
- ❑ ***Influenza***
- ❑ ***Pleurisy***
- ❑ ***Arthritis***
- ❑ ***Epilepsy***
- ❑ ***Mental Disorders***
- ❑ ***Eczema***

❑ *I have no discomfort, I am here for a check-up and Wellness care.*

❑ *I do have discomfort in the following areas:*

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Include all affected areas.

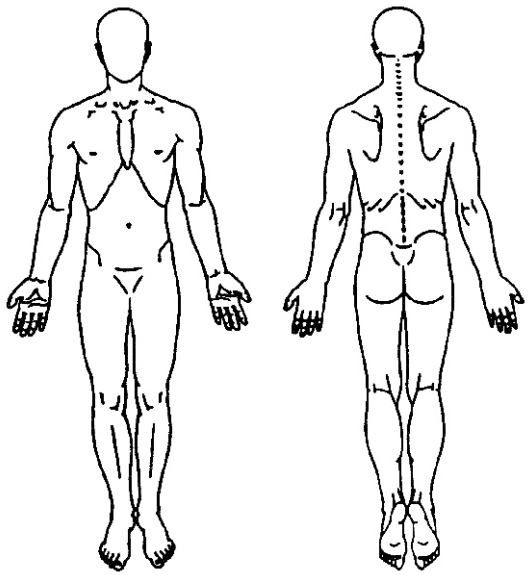
Numbness ●●●

Pins & Needles ○ ○ ○

Burning **X X X**

Aching **A A A**

Stabbing **/ / /**



Please mark on the line below where you would describe your pain level today.

No Pain ——————————— **Worst Pain**