

WELCOME TO OUR OFFICE!

YOUR CAREFUL COMPLETION OF THIS FORM WILL HELP US BETTER CARE FOR YOUR NEEDS.

DATE: _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

ADDRESS _____ CITY _____ PROVINCE _____

POSTAL CODE _____ HOME PHONE _____ CELL PHONE _____

A.H.C. NUMBER _____ Male Female DATE OF BIRTH _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

IS THIS A WORKER'S COMPENSATION INJURY? (Y) (N) IF YES, SOCIAL INSURANCE NUMBER _____

OCCUPATION _____ EMPLOYER _____

BUSINESS ADDRESS _____ WORK PHONE _____

MARITAL STATUS (M) (S) (W) (D) NAME OF SPOUSE _____ SPOUSE'S WORK PHONE _____

YOUR MAJOR COMPLAINT/ SYMPTOMS _____

WHEN AND HOW DID THIS CONDITION START? _____

HOW WOULD YOU DESCRIBE YOUR PAIN? Sharp / Burning / Ache / Tightness / Searing / Toothache / Lightning / Electrical / Boring / Other _____

WHAT AGGRAVATES YOUR CONDITION? _____

IS THE CONDITION GETTING WORSE? (Y) (N) _____

WHAT MAKES THE CONDITION BETTER? _____

HAVE YOU HAD THIS OR A SIMILAR CONDITION IN THE PAST? (Y) (N) IF YES, WHEN _____

ARE YOU SEEING OR HAVE YOU SEEN YOUR MEDICAL DOCTOR FOR THIS CONDITION? (Y) (N) PHYSIOTHERAPIST? (Y) (N)

ANY X-RAYS TAKEN OF THE AREA OF COMPLAINT? (Y) (N) IF YES, WHEN _____ WHERE _____

WHAT MEDICATIONS ARE YOU NOW TAKING? _____

ANY OTHER COMPLAINTS OR SYMPTOMS? _____

PREVIOUS SURGERY, ILLNESS, CAR ACCIDENTS OR WORK INJURIES _____

WHEN WAS THE LAST TIME YOU WERE HOSPITALIZED? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? (Y) (N) IF YES, WHEN _____

WHAT WERE YOU TREATED FOR? _____ CHIROPRACTOR'S NAME: _____

FAMILY DOCTOR'S NAME _____ DATE OF LAST PHYSICAL EXAM _____

DO YOU HAVE ANY OTHER HEALTH PROBLEMS FOR WHICH YOU ARE SEEING YOUR DOCTOR? IF YES, PLEASE DESCRIBE.
