

PATIENT ENTRANCE HISTORY

(Please Print)

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Home Telephone: () _____ Cell Phone: () _____

Date of Birth (D/M/Y) _____ Age _____ Marital Status - **S M D W Sep** (Please Circle One)

Spouse's Name _____ Children _____

Patient's Occupation _____

Employer's Name & Address _____ Phone () _____

Have you been to a Chiropractor before? Yes No Chiropractor's Name: _____

If so, when was your last visit? _____

How did you hear about our clinic? _____

Referred By: _____

Provincial Health Card Number _____ Code _____ Expiry Date _____

HEALTH QUESTIONNAIRE

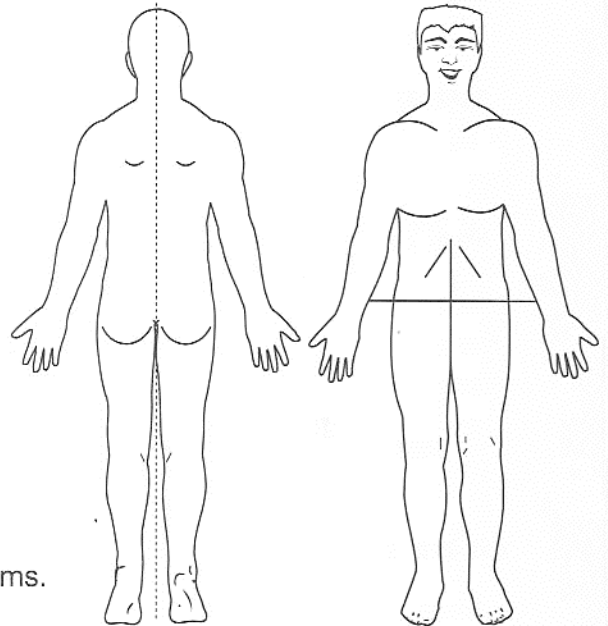
1. What is your major complaint?

2. How long has it been present?

3. What do you think has caused this problem?

4. Please indicate the area of complaint on the diagrams.

5. Please indicate, on the line, the severity of your symptoms.



No Pain

Worst Pain Imaginable

Please turn page over

6. Have you had any of the following illnesses? (please \checkmark all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> stroke | <input type="checkbox"/> hernia |
| <input type="checkbox"/> anaemia | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> arthritis | <input type="checkbox"/> cancer |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> AIDS |

7. Have you had any other illnesses? _____

8. Do you have any of the following symptoms? (please \checkmark all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> headaches | <input type="checkbox"/> sprains or fractures |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> earaches | <input type="checkbox"/> tremors |
| <input type="checkbox"/> chronic cough | <input type="checkbox"/> dizziness | <input type="checkbox"/> weakness |
| <input type="checkbox"/> allergies | <input type="checkbox"/> blackouts | <input type="checkbox"/> arm / hand pain or numbness |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> blurred vision | <input type="checkbox"/> leg / foot pain or numbness |
| <input type="checkbox"/> nausea / vomiting | <input type="checkbox"/> frequent urination | <input type="checkbox"/> neck pain or stiffness |
| <input type="checkbox"/> rapid weight change | <input type="checkbox"/> difficult urination | <input type="checkbox"/> back pain or stiffness |
| <input type="checkbox"/> depression | <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> swollen joints |
| <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> swollen glands | <input type="checkbox"/> muscle spasms |

9. In your immediate family (parents, brothers or sisters) is there any history of:

- stroke heart disease cancer

10. Have you ever been involved in a motor vehicle accident? Yes No

11. In what position do you usually sleep? _____

12. List any surgical operations and dates?

13. Have you been hospitalized for other than surgery? Yes No

If so, please explain _____

14. List any pills, vitamins, or medications:

15. How much do you exercise? (type and frequency) _____

16. Do you smoke? Yes No If so, how much? _____

Signature