

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ #CHILDREN: \_\_\_\_\_  
 EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

Who referred you to this clinic?: \_\_\_\_\_  
 Do you have any extended health care insurance? YES  NO   
 Chiropractic, Massage Therapy, or Orthotic Coverage? YES  NO   
 Is this a WSIB (Workman's Comp) case? YES  NO

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of last spinal x-rays: \_\_\_\_\_ Where?: \_\_\_\_\_  
 Have you ever consulted a chiropractor?: \_\_\_\_\_ If yes, Dr. \_\_\_\_\_ When?: \_\_\_\_\_  
 What is your chief complaint?: \_\_\_\_\_

When did this start?: \_\_\_\_\_  
 Have you had any car accidents, falls or fractures? Please list all & approximate dates for each: \_\_\_\_\_

Are you under any stress?: \_\_\_\_\_ List drugs you take: \_\_\_\_\_

Have you had any of the following surgery/conditions?

- |   |                                       |                                       |                                       |
|---|---------------------------------------|---------------------------------------|---------------------------------------|
| SPINAL SURGERY <input type="checkbox"/> | GALL BLADDER <input type="checkbox"/> | TONSILS <input type="checkbox"/>      | HYSTERECTOMY <input type="checkbox"/> |
| HEART SURGERY <input type="checkbox"/>  | CESAREAN <input type="checkbox"/>     | DIABETES <input type="checkbox"/>     | STROKE <input type="checkbox"/>       |
| CANCER <input type="checkbox"/>         | HEART ATTACK <input type="checkbox"/> | OSTEOPOROSIS <input type="checkbox"/> | OTHER <input type="checkbox"/>        |

Please check any problems you presently have or have had in the past year, (Many symptoms can be a result of nerve/tension to those areas of the body):

**CERVICAL SPINE (NECK)**

- NECK PAIN
- HEADACHES
- SHOULDER PAIN (BURSITIS)
- TENNIS ELBOW/WRIST PAIN
- PAIN RADIATING TO THE ARM/HAND
- JAW PROBLEMS
- DIZZINESS
- NERVOUSNESS
- RECURRING EARACHES/INFECTIONS
- RECURRING SINUS CONGESTION
- VISUAL DISTURBANCES
- DEPRESSION
- ANXIETY
- DIFFICULTY SLEEPING
- NAUSEA/VOMITING
- FATIGUE

**LUMBAR SPINE (LOWER BACK)**

- LOWER BACK PAIN
- SACROILIAC PAIN
- PAIN RADIATING INTO THE LEG
- NUMBNESS INTO THE FOOT
- KNEE PAIN/ANKLE/FOOT PAIN
- GROIN AND/OR TESTICULAR PAIN
- CONSTIPATION/DIARRHEA
- HEMORRHOIDS
- BLADDER CONTROL PROBLEMS
- FREQUENT URINATION AT NIGHT
- IMPOTENCE
- IRREGULAR MENSTRUAL CYCLE
- MENSTRUAL CRAMPS/BACK PAIN
- DIFFICULTY GETTING PREGNANT

**THORACIC SPINE (MIDDLE BACK)**

- PAIN BETWEEN SHOULDER BLADES
- PAIN INTO THE RIBS
- PAIN RADIATING TO CHEST
- SHINGLES
- ASTHMA
- HEART PALPITATIONS
- RECURRING INDEGESTION
- GAS/BELCHING
- NAUSEA/VOMITING

**GENERAL SYMPTOMS**

- ALLERGIES
- UNEXPLAINED WEIGHT LOSS
- SLURRED SPEECH
- LOSS OF SMELL/TASTE
- NUMBNESS OF FACE/LIPS/TONGUE

Are you pregnant? YES  NO  NOT APPLICABLE

Do you smoke? If yes, how much?: \_\_\_\_\_

Do you exercise? If yes, how much?: \_\_\_\_\_