**Patient Name:** ______________________ **Date:** ____________

**Sask Health Number:** ______________________ **Date of Birth:** day / month / year

**Address:** ______________________ **City:** ____________

**Postal Code:** ____________ **Phone:** home or cell ____________ work ____________

**Occupation:** ______________________ **Employer:** ____________

**Next of Kin:** ______________________ **Physician:** ____________

**Have you seen a Chiropractor before?** yes / no **If yes, who?** ____________

**Primary complaint location:** ☐ Headache ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back

☐ Other ____________ ☐ Right Side ☐ Left Side

**Height:** ____________ **Weight:** ____________ **Stress Level:** ☐Low ☐ Med ☐ High

**Medical History:**

**Yourself:** ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Heart Attack ☐ Diabetes ☐ Stress ☐ Other:

**Parents:** ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Heart Attack ☐ Diabetes ☐ Stress ☐ Other:

**Medications:** ______________________

**Please fill in ONLY if this is an** ☐ **SGI or** ☐ **WCB claim:**

**Injury Date:** ____________ **Claim Number:** ____________

**This Section for the Chiropractor / Office :**

Onset: D M Y Course: C P B

Radiation: A H F B L T

Aggravating:

Relieving:

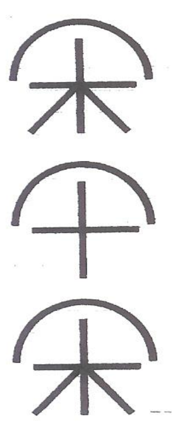
Associated S N T P&N B I

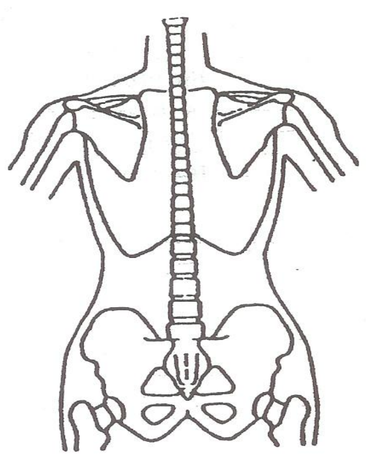
Previous History/Traumas/Injuries and Treatment: Yes / No

Systems: EENT GI GU

Posture Analysis: AC: L R Inf. Scapula: L R Iliac Crests: L R Trochanters: L R

Examination:





Orthopedic/Muscular Screen:

| | Left | Right |
|---|---|---|
| SLR | | |
| Thomas | | |
| ASIS | | |
| Psoas Palp | | |
| SI Compr | | |
| Yoemans | | |
| Prone SLR | | |
| Axial Com | | |
| Axial Trac | | |
| Jacksons | | |
| Spurlings | | |
| Doorbell | | |
| Kemps | | |

Neurological Evaluation

| | Reflexes | Motor | Sensory | Path |
|---|---|---|---|---|
| Upper | | | | |
| Lower | | | | |

OTHER ______________________

Diagnosis:

Management:

Prognosis: G F P

Recommendations: Ice Stretches RMT Visit MD X Rays:__________________ Other:____________________________