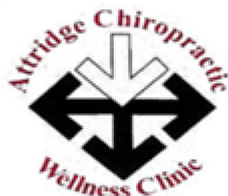


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## PATIENT INFORMATION

**Name:** ________________________________________ **Health card #:** _______________________ **Date:** _________________

**Address:** ________________________________ **City:** ___________________ **Prov.:** _______ **Postal code:** _______________

**Phone:** _______________ /_______________ **Email:** __________________________________________________________

**Date of Birth:** __dd__ /__mm__ /__yyyy__ **Height:** ________________ **Weight:** ________________ **Stress Level:** □ Low □ Med □ High

**Occupation:**__________________________________________ **Next of Kin:**____________________#____________________

**Have you seen a Chiropractor before? Y / N If yes, who?** ___________________________ **Have you had Acupuncture? Y / N**

**Medical History**

**Yourself:** □ **Cancer** □ **Stroke** □ **High Blood Pressure** □ **Diabetes** □ **Stress** □ **Other:** ___________________________________

**Parents:** □ **Cancer** □ **Stroke** □ **High Blood Pressure** □ **Diabetes** □ **Stress** □ **Other:** ___________________________________

**Medication:** ____________________________________________________________________________________________

**Previous relevant surgery:** __________________________________ **Have you had X-Rays? Y / N Date:** __________________

Are you here for a WCB or SGI Claim? **Y / N**
Injury Date: _________________________________ Claim Number: _______________________________________

## MEDICAL HISTORY AND SYMPTOM/PAIN INFORMATION

Reason for today's visit:
□New Injury □Old Injury □Chronic Pain □Wellness

Are you in pain: Yes / No

Rate your pain below:
*None* 1 2 3 4 5 6 7 8 9 10 *Intense*

**WOMEN ONLY:**
Are you pregnant? Yes / No
How many weeks? ____________________________

Symptoms you have experienced in the past 6 months:

□ Low Back Pain
□Pain Between Shoulder Blades
□Neck Pain
□Tension/Migraine Headaches
□Tired/Fatigued
□ High/Low Blood Pressure
□ Tension Across Top of Shoulders
□ Numbness/Tingling in Arms or Hands
□ Numbness/Tingling in Legs or Feet
□ Dizziness
□Ringing in Ears
□ Nervous
□ Difficulty Sleeping
□ Allergies
□ Digestive Problems
□ Weight Problems
□Blood Clotting Issues

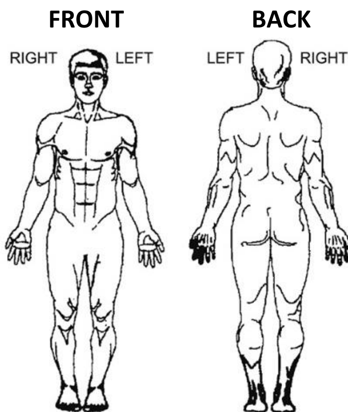
□ Other: ______________________________________________

### PAIN DIAGRAM

Please complete the following 'Pain Diagram' by using letters to indicate your areas of pain.

P PAIN
T TINGLING
N NUMBNESS
B BURNING
S STIFFNESS

**FRONT** **BACK**




What makes you feel better? ____________________________