Patient History Information

Date:_____ File Number_____
Name:_____ DOB:_____
Address:_____ Gender: M/F
City:_____ Province:_____ Postal Code:_____
Home:_____ Work:_____ Cell/Other:_____
Email:_____ Preferred method of Contact: Email Home Cell Work
Occupation: _____ Which of our patients referred you? _____

Medical Care Information:
Name of Family Doctor: _____ N/A
Address: _____ City_____ Province_____
Have you ever seen a Chiropractor? Y / N Name of Chiropractor: _____
Date of last Visit: _____ How long did you receive treatment? _____City_____
Have you recently had any of the following? X-rays MRI Catscan UltraSound
Have you had any surgeries in the last 5 years? Y / N If yes, what was the date? _____
Reason for surgery_____
What is your chief health complaint today?_____

Past & Present Illness /Conditions:

☐ AIDS	☐ Cancer	☐ Epilepsy	☐ Multiple Sclerosis	☐ STI'S
☐ Allergies	☐ Cirrhosis/Hepatitis	☐ Heart Problem	☐ Pacemaker	☐ TMJ Disorder
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Prostate Trouble	☐ Thyroid Trouble
☐ Arthritis **OA/RA**	☐ Digestive Problems	☐ HIV/ARC	☐ Scoliosis	☐ Tuberculosis
☐ Asthma	☐ Dislocated Joints	☐ Kidney Trouble	☐ Sinus Trouble	☐ Ulcer
☐ Bone Fracture	☐ Diverticulitis	☐ Low Blood Pressure	☐ Spinal Disc Disease	☐ Weight Problem
☐ **Concussion(s) Number of concussions: Date of 3 most recent:**				
Other:				

Please list allergies and if they are anaphylactic_____

Have you ever experienced any of the following symptoms or events?

☐ Cold Feet/ Hands	☐ Headaches	☐ Neck Pain	☐ Occupational Stress
☐ Constipation/Diarrhea	☐ Low Back Pain	☐ Numbness or Pins in Arms/Hands	☐ Physical Stress
☐ Ears Ringing	☐ Migraines	☐ Numbness or Pins in Legs/Feet	☐ Personal/Mental Stress
☐ Motor Vehicle Accident(s) **Date(s):**			

Please list any notable falls or injuries:_____
What is your current sleep position: back / stomach / left side / right side
What are your current hobbies/sports? _____

Family History of Illness:

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ Stroke
Other:				

Social History:
Alcohol ☐ No ☐ Yes Drinks per week?
Cigarettes ☐ No ☐ Yes Packs per day?
Caffeine ☐ No ☐ Yes Drinks per day?
Exercise ☐ No ☐ Yes, hours per week? (circle one) Light / Moderate / Strenuous

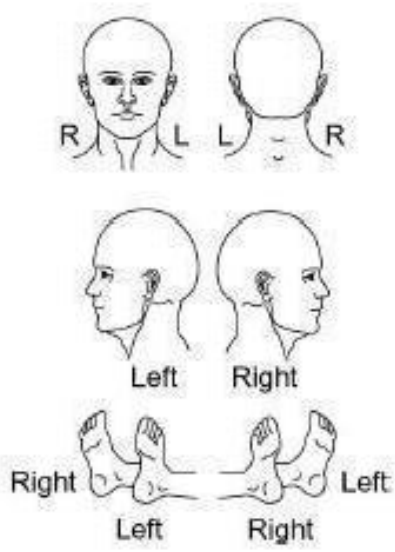
Signature: _____ Date: _____

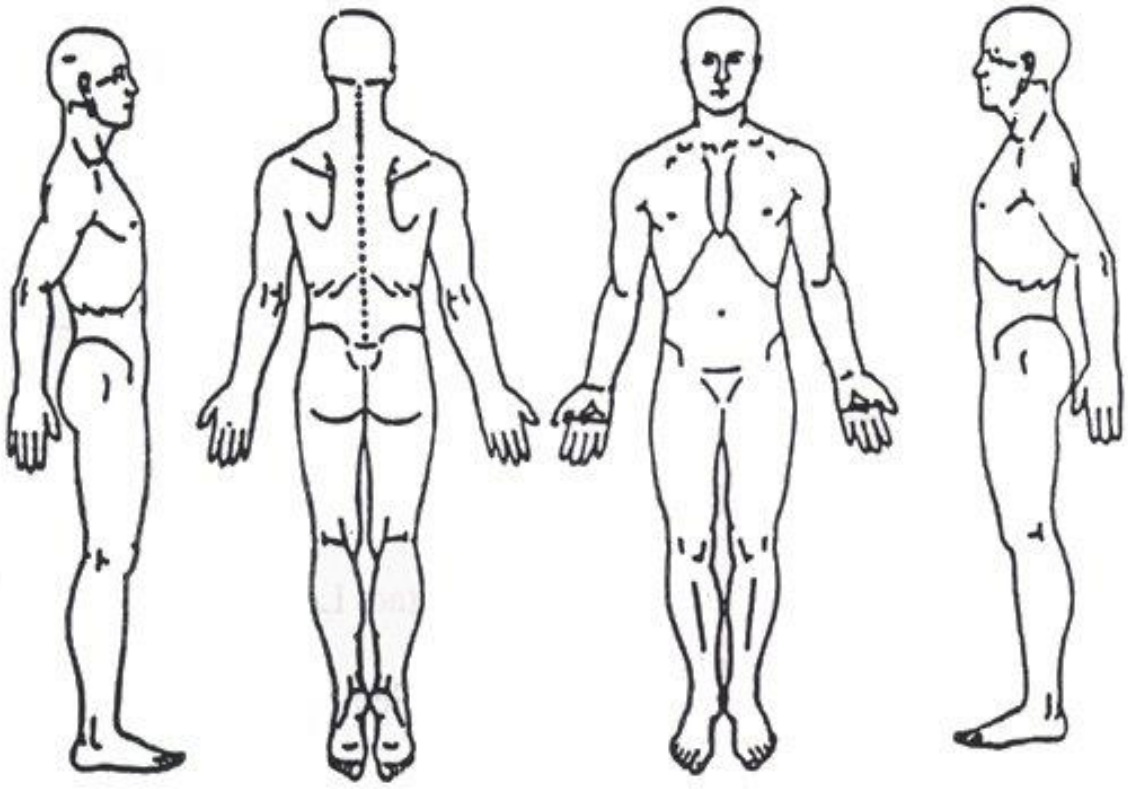
All questions contained in this questionnaire are strictly confidential and will become part of your records at our office.

Dr. Sheldon Campbell, B.S.c., D.C. & Dr. Matthew McKeagan, B.Kin., D.C.
208-1002 Beaverbrook Rd Kanata, Ontario K2K 1L1 Phone: 613-592-8656

Using the appropriate letters from the legend below, please mark any and all areas where you feel any sensation that is unusual or abnormal.

A	Ache
B	Burning
M	Muscle Spasm
N	Numbness
PN	Pins & Needles
S	Stiffness
ST	Stabbing





Please rate your pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

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