# Patient Information Form

Name:_____ Birth date: _____ Marital Status: **S M CL W D**
(please circle one)
Address:_____ City:_____ Postal Code:_____

Home Phone#:_____ Work#:_____ Cell #:_____ (required for text reminder)

Text Appointment Reminder? **Y/N** If yes, cell provider ie) Telus/ Rogers:_____
E-mail address:_____ Email Appointment Reminder? **Y/N**

Referred to us by:_____
Occupation:_____ Employer:_____
Emergency Contact:_____, relation to you:_____ Phone#:_____
Family Physician:_____ Location:_____

Is this condition part of an ICBC or WCB claim? **Y/N** **If yes, please ask for additional forms.**
Have you obtained an attorney? **Y/N** If yes, attorney's name:_____

What is your major complaint? _____
_____
Other complaints?_____
_____

Are these symptoms: **A)** getting worse **B)** improving **C)** about the same **D)** come and go ?

Please circle any activities that aggravate your condition:
**A)** standing **B)** sitting **C)** walking **D)** lying **E)** bending **F)** lifting **G)** twisting **H)** coughing
Have you had these symptoms before? **Y/N** If yes, when?_____

Have you had prior chiropractic care? **Y/N** If yes, doctor's name:_____

Have you seen another doctor for THIS condition? **Y/N** If yes, doctor's name:_____
Date consulted:_____, diagnosis:_____ Were X-rays taken? **Y/N**

Are you on ANY medication? **Y/N** If yes, please list:_____
_____
_____
Have you EVER been in a motor vehicle accident? **Y/N** If yes, when?: _____
*Female only:* Are you pregnant? **Yes/No/Maybe**

**I hereby acknowledge that all of the information herein is correct to the best of my ability:**

Signature of Patient:_____ Date:_____
-or parent/guardian if under 19 years

## Please complete reverse side⇒ ⇒ ⇒

# PATIENT PAST HISTORY FORM

Name:_____ Date:_____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

C=Constant F=Frequent O=Occasional

**C F O**

**NEUROLOGICAL**

- ☐ ☐ ☐ allergy
- ☐ ☐ ☐ chills
- ☐ ☐ ☐ convulsions
- ☐ ☐ ☐ dizziness
- ☐ ☐ ☐ fainting
- ☐ ☐ ☐ fevers
- ☐ ☐ ☐ headaches
- ☐ ☐ ☐ loss of sleep
- ☐ ☐ ☐ nervousness
- ☐ ☐ ☐ depression
- ☐ ☐ ☐ neuralgia
- ☐ ☐ ☐ numbness
- ☐ ☐ ☐ sweats
- ☐ ☐ ☐ loss of weight
- ☐ ☐ ☐ tremors

**MUSCLE & JOINT**

- ☐ ☐ ☐ arthritis
- ☐ ☐ ☐ bursitis
- ☐ ☐ ☐ foot trouble
- ☐ ☐ ☐ hernia
- ☐ ☐ ☐ low back pain
- ☐ ☐ ☐ neck pain
- ☐ ☐ ☐ neck stiffness
- ☐ ☐ ☐ pain between shoulders

**RESPIRATORY**

- ☐ ☐ ☐ chronic cough
- ☐ ☐ ☐ wheezing
- ☐ ☐ ☐ difficulty breathing
- ☐ ☐ ☐ spitting blood
- ☐ ☐ ☐ throat phlegm

**EYES,EARS, NOSE & THROAT**

- ☐ ☐ ☐ colds
- ☐ ☐ ☐ crossed eyes
- ☐ ☐ ☐ deafness
- ☐ ☐ ☐ dental decay
- ☐ ☐ ☐ asthma
- ☐ ☐ ☐ ear aches
- ☐ ☐ ☐ ear discharges
- ☐ ☐ ☐ ear noises

**C F O**

- ☐ ☐ ☐ sinus infections
- ☐ ☐ ☐ enlarged glands
- ☐ ☐ ☐ sore throat
- ☐ ☐ ☐ tonsillitis
- ☐ ☐ ☐ eye pain
- ☐ ☐ ☐ failing vision
- ☐ ☐ ☐ far sighted
- ☐ ☐ ☐ gum trouble
- ☐ ☐ ☐ hay fever
- ☐ ☐ ☐ hoarseness
- ☐ ☐ ☐ nasal obstruction
- ☐ ☐ ☐ near sighted
- ☐ ☐ ☐ nosebleeds

**CARDIO-VASCULAR**

- ☐ ☐ ☐ slow heart beat
- ☐ ☐ ☐ rapid heart beats
- ☐ ☐ ☐ hardening of arteries
- ☐ ☐ ☐ high blood pressure
- ☐ ☐ ☐ low blood pressure
- ☐ ☐ ☐ pain over heart
- ☐ ☐ ☐ swelling of ankles
- ☐ ☐ ☐ poor circulation

**GASTRO INTESTINAL**

- ☐ ☐ ☐ excessive hunger
- ☐ ☐ ☐ burping or gas
- ☐ ☐ ☐ liver trouble
- ☐ ☐ ☐ colitis
- ☐ ☐ ☐ colon trouble
- ☐ ☐ ☐ constipation
- ☐ ☐ ☐ diarrhoea
- ☐ ☐ ☐ difficult digestion
- ☐ ☐ ☐ distension of abdomen
- ☐ ☐ ☐ stomach pain
- ☐ ☐ ☐ gall bladder trouble
- ☐ ☐ ☐ haemorrhoids
- ☐ ☐ ☐ intestinal worms
- ☐ ☐ ☐ jaundice
- ☐ ☐ ☐ poor appetite
- ☐ ☐ ☐ nausea
- ☐ ☐ ☐ vomiting
- ☐ ☐ ☐ vomit blood

**C F O**

**SKIN**

- ☐ ☐ ☐ boils
- ☐ ☐ ☐ bruise easily
- ☐ ☐ ☐ dryness
- ☐ ☐ ☐ hives or allergy
- ☐ ☐ ☐ itching
- ☐ ☐ ☐ skin rash
- ☐ ☐ ☐ varicose veins

**GENITO-URINARY**

- ☐ ☐ ☐ bed wetting
- ☐ ☐ ☐ blood in urine
- ☐ ☐ ☐ frequent urination
- ☐ ☐ ☐ loss control urine
- ☐ ☐ ☐ kidney infection
- ☐ ☐ ☐ painful urination
- ☐ ☐ ☐ prostate trouble
- ☐ ☐ ☐ pus in urine
- ☐ ☐ ☐ smell in urine

**PAIN OR NUMBNESS IN:**

- ☐ ☐ ☐ shoulders
- ☐ ☐ ☐ arms
- ☐ ☐ ☐ hands
- ☐ ☐ ☐ hips
- ☐ ☐ ☐ legs
- ☐ ☐ ☐ knees
- ☐ ☐ ☐ ankles
- ☐ ☐ ☐ feet
- ☐ ☐ ☐ painful tail bone
- ☐ ☐ ☐ sciatica
- ☐ ☐ ☐ swollen joints

**FOR WOMEN ONLY**

- ☐ ☐ ☐ cramps
- ☐ ☐ ☐ heavy flow
- ☐ ☐ ☐ light flow
- ☐ ☐ ☐ irregular cycle
- ☐ ☐ ☐ painful cycle
- ☐ ☐ ☐ discharge
- ☐ ☐ ☐ sore breasts

Menopausal: YES / NO Pregnant: YES / NO

Last menstruation date: _____

Due date if pregnant :_____