OUTLINE OF PROCEDURE FOR NEW PATIENTS

STEP ONE: All new patients are required to complete a personal health/history questionnaire.

STEP TWO: Your consultation with a doctor to discuss your health problems.

STEP THREE: Diagnostic, chiropractic, orthopedic and neurological examination procedures to determine if chiropractic is appropriate for your condition.

STEP FOUR: The doctor will advise you as to the need of additional procedures such as laboratory and x-ray tests, if necessary.

STEP FIVE: Your recommended treatment program will be explained to you.

STEP SIX: Treatment will begin and continue as scheduled until your condition has been fully corrected, or until maximum possible improvement has been obtained.

AQUAINTANCE INFORMATION

THE DATA ON THIS CONFIDENTIAL FORM IS ESSENTIAL IF WE ARE TO RENDER THE BEST POSSIBLE CARE. WE APPRECIATE YOUR COOPERATION IN FILLING IT OUT.

DATE: ______________

PERSONAL INFORMATION

LAST NAME	**FIRST NAME**	**PHONE NUMBER:**	
HOME ADDRESS	**CITY:**	**PROVINCE:**	**POSTAL CODE**
DATE OF BIRTH DD: MM: YY:	**OCCUPATION**	**EMPLOYER**	**BUSINESS PHONE:**

EMERGENCY CONTACT: **Name:** **Ph.#:**	**BY WHOM WERE YOU REFERRED?**

ALBERTA HEALTH CARE #:	**EMAIL ADDRESS: (Appointment Reminders Only)**

CHIROPRACTIC HEALTH INFORMATION

Have you had previous chiropractic care? YES NO Doctor: ____________________________ Were X-Rays taken? YES NO

What were you treated for? ____

What is your major complaint at the present time? ____

How long have you had this condition? ____

Have you had this or a similar condition in the past? YES NO When? ___________________________

Is this condition getting progressively worse? YES NO How so? _______________________________

Is this condition interfering with your: Work__ Sleep__ Daily Routine__ Other:_____________________

Other complaints: ____

What activities improve your condition? ____

How long has it been since you felt really good? ____

Please list any surgical operations & year performed____

Name of medical doctor____

Are you currently taking Birth Control__ Insulin__ Muscle Relaxants__ Pain Meds__ Heart Medication__ Vitamins__

Age of Mattress: ___ years Comfortable__ Uncomfortable__ How do you sleep? Back__ Side__ Stomach__ Combo__

Have you ever been involved in an auto accident? YES__ NO__ Please describe: _____________________

____

Have you had any other personal injury or accident? ____

MEDICAL HEALTH INFORMATION

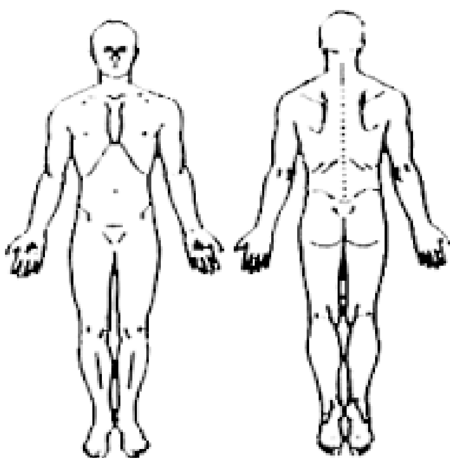
Have you ever been diagnosed or told you have the following? Please circle your response.

1. High Blood Pressure	Yes	No
2. Hardening of the arteries (arteriosclerosis)	Yes	No
3. Diabetes	Yes	No
4. Tuberculosis	Yes	No
5. Cancer, Where:	Yes	No
6. Heart or blood disease	Yes	No
7. Bone spurs of the neck bones (cervical sprain)	Yes	No
8. Whiplash injury (flexion-extension injury, cervical pain)	Yes	No
9. Have you or any of your relatives ever suffered a stroke?	Yes	No
10. Were you ever a smoker? From: To:	Yes	No
11. Visual disturbances (blurring, loss, double)	Yes	No
12. Hearing disturbances (loss, ringing, other noise)	Yes	No
13. Slurred speech or other speech problems	Yes	No
14. Difficulty swallowing	Yes	No
15. Dizziness	Yes	No
16. Loss of consciousness, even momentary blackouts	Yes	No
17. Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs or any other part of your body	Yes	No
18. Sudden collapse without loss of consciousness	Yes	No

On the picture below, please use the indicated marks to show areas where you have, at any time experienced:

PAIN: XXXX **NUMBNESS: ////** **TINGLING: 0000**

Please circle the areas you are currently experiencing pain or discomfort:



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For the dominant area of pain, how would you judge that pain on a scale of zero to ten?

On average: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10