BACK & BODY HEALTH
CHIROPRACTIC/ART FORM

PERSONAL INFORMATION			
Name:			Today's Date (mm/dd/yyyy):
Date of birth (mm/dd/yyyy)		Age:	Gender:
Address			Height: Weight: Last blood pressure reading:
City:	Province:		Postal Code:
Home/Cell Phone:		Work Phone:	
Your occupation:		Employer:	
E-mail address:			
Permission for correspondence through		❑ Phone ❑ Mail ❑ Occasion cards ❑ E-mail ❑ Other:	

Spouse /Partner:	Children: ❑Yes ❑ No
In case of emergency, whom should we notify?	
Relation to you:	Contact number:

Alberta Health Care Number:	Family Doctor:
Extended Health Care Company:	

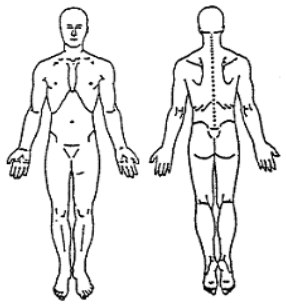
How did you hear about our office ❑ Doctor ❑ Friend ❑ Sign ❑ Internet ❑ Other: _____
If you checked friend who can we thank:

REASON FOR APPOINTMENT

What is your chief complaint?

Describe the onset

Provide the primary symptoms



Using an "X", please rate your pain on the line below

No Pain _____Very Painful

1 5 10

Is this a car accident case: ❑ Yes ❑ No	Have you recently been in an accident: ❑ Yes ❑ No
***** If YES, please fill out Notice of loss & Proof of Claim (form AB-1) and MVA form *****	
If this is a WCB case please let us know as we do not accept WCB claims	

Have you seen any other physician or health care professional for this complaint? ❑ Yes ❑ No		
If YES, Doctors Name:	Date of last treatment:	
Diagnosis:	What type of treatment did you receive:	

PREVIOUS CHIROPRACTIC &/or ACTIVE RELEASE TECHNIQUES		
Clinic Name:	Doctor's Name:	Date of last treatment:
Were X-Rays taken? ❑ Yes ❑ No	If yes, when?	
Results: ❑ Excellent ❑ Good ❑ Fair ❑ Poor		

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HEALTH HISTORY	
Name:	Today's Date (mm/dd/yyyy):
Please check the appropriate box of any of the following symptoms that you now have or have had previously.	
If the symptom is not applicable to you, please leave blank.	

C = Constant F= Frequent O = Occasional

C F O	C F O	C F O
NEUROLOGIC	❑ ❑ ❑ enlarged glands	SKIN
❑ ❑ ❑ chills	❑ ❑ ❑ enlarged thyroid	❑ ❑ ❑ boils
❑ ❑ ❑ convulsions	❑ ❑ ❑ sore throat	❑ ❑ ❑ bruise easily
❑ ❑ ❑ dizziness	❑ ❑ ❑ tonsillitis	❑ ❑ ❑ dryness
❑ ❑ ❑ fainting	❑ ❑ ❑ eye pain	❑ ❑ ❑ hives
❑ ❑ ❑ fevers	❑ ❑ ❑ failing vision	❑ ❑ ❑ itching
❑ ❑ ❑ headaches	❑ ❑ ❑ far sighted	❑ ❑ ❑ skin rash
❑ ❑ ❑ loss of sleep	❑ ❑ ❑ near sighted	❑ ❑ ❑ varicose veins
❑ ❑ ❑ nervousness	❑ ❑ ❑ gum trouble	GENITO-URINARY
❑ ❑ ❑ depression	❑ ❑ ❑ hay fever	❑ ❑ ❑ bed wetting
❑ ❑ ❑ neuralgia	❑ ❑ ❑ hoarseness	❑ ❑ ❑ blood in urine
❑ ❑ ❑ numbness	❑ ❑ ❑ nasal obstruction	❑ ❑ ❑ frequent urination
❑ ❑ ❑ sweats	❑ ❑ ❑ nose bleeds	❑ ❑ ❑ urination control issues
❑ ❑ ❑ loss of weight	CARDIO-VASCULAR	❑ ❑ ❑ kidney infection
❑ ❑ ❑ tremors	❑ ❑ ❑ rapid heart beats	❑ ❑ ❑ painful urination
MUSCLE & JOINT	❑ ❑ ❑ slow heart beats	❑ ❑ ❑ prostate trouble
❑ ❑ ❑ arthritis	❑ ❑ ❑ swelling of ankles	❑ ❑ ❑ pus in urine
❑ ❑ ❑ bursitis	❑ ❑ ❑ hardening of arteries	❑ ❑ ❑ smell of urine
❑ ❑ ❑ foot trouble	❑ ❑ ❑ high blood pressure	PAIN OR NUMBNESS
❑ ❑ ❑ hernia	❑ ❑ ❑ low blood pressure	❑ ❑ ❑ shoulders
❑ ❑ ❑ low back pain	❑ ❑ ❑ pain over heart	❑ ❑ ❑ arms
❑ ❑ ❑ neck pain	❑ ❑ ❑ poor circulation	❑ ❑ ❑ hands
❑ ❑ ❑ neck stiffness	GASTRO INTESTINAL	❑ ❑ ❑ hips
❑ ❑ ❑ shoulder pain	❑ ❑ ❑ excessive hunger	❑ ❑ ❑ legs
RESPIRATORY	❑ ❑ ❑ burping or gas	❑ ❑ ❑ knees
❑ ❑ ❑ chest pain	❑ ❑ ❑ liver trouble	❑ ❑ ❑ ankles
❑ ❑ ❑ chronic cough	❑ ❑ ❑ colitis	❑ ❑ ❑ feet
❑ ❑ ❑ difficulty breathing	❑ ❑ ❑ colon trouble	❑ ❑ ❑ painful tail bone
❑ ❑ ❑ spitting blood	❑ ❑ ❑ constipation	❑ ❑ ❑ sciatica
❑ ❑ ❑ throat phlegm	❑ ❑ ❑ diarrhea	❑ ❑ ❑ swollen joints
❑ ❑ ❑ wheezing	❑ ❑ ❑ difficult digestion	FOR WOMEN ONLY
EYES, EARS, NOSE, & THROAT	❑ ❑ ❑ distention of abdomen	❑ ❑ ❑ cramps
❑ ❑ ❑ colds	❑ ❑ ❑ stomach pain	❑ ❑ ❑ heavy flow
❑ ❑ ❑ crossed eyes	❑ ❑ ❑ gall bladder trouble	❑ ❑ ❑ light flow
❑ ❑ ❑ deafness	❑ ❑ ❑ hemorrhoids	❑ ❑ ❑ irregular cycle
❑ ❑ ❑ dental decay	❑ ❑ ❑ intestinal worms	❑ ❑ ❑ painful cycle
❑ ❑ ❑ asthma	❑ ❑ ❑ jaundice	❑ ❑ ❑ discharge
❑ ❑ ❑ ear aches	❑ ❑ ❑ poor appetite	❑ ❑ ❑ sore breasts
❑ ❑ ❑ ear discharges	❑ ❑ ❑ nausea	❑ Yes ❑ No menopausal
❑ ❑ ❑ ear noises	❑ ❑ ❑ vomiting	Last menstruation date:
❑ ❑ ❑ sinus infection	❑ ❑ ❑ blood in vomit	❑ Yes ❑ No pregnant
		Due date:

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BACK & BODY HEALTH
CHIROPRACTIC/ART FORM

HEALTH & LIFESTYLE	
Name:	Today's Date (mm/dd/yyyy):

DIET					
How many meals do you eat per day?	❑ 1	❑ 2	❑ 3	❑ 4+	
Which meals do you eat regularly?	❑ Breakfast		❑ Lunch		❑ Dinner
Do you eat dairy products (Milk, Cheese, Yogurt, etc.)?	❑ Yes	❑ No			
Are you a vegetarian?	❑ Yes	❑ No	If yes, how long:		
How much coffee do you drink per day?	❑ 0	❑ 1-2	❑ 3-4	❑ 5-6	❑ 7+
How much pop do you drink per day?	❑ 0	❑ 1-2	❑ 3-4	❑ 5-6	❑ 7+
How much water do you drink per day in glasses?	❑ 1-3	❑ 4-6	❑ 7-9	❑ 10-12	❑ 12+
Do you often feel hypoglycemic (low blood sugar)?	❑ Yes	❑ No			
How many bowel movements do you have a day?	❑ 0	❑ 1	❑ 2	❑ 4	❑ 4+
HABITS					
How many drinks of alcohol per week do you consume?	❑ 0	❑ 1-2	❑ 3-4	❑ 5-6	❑ 7+
Do you smoke?	❑ Yes	❑ No			
How much do you smoke in packs per day?	❑ 1/4	❑ 1/2	❑ 3/4	❑ 1	❑ 1+
Have you ever smoked?	❑ Yes	❑ No	If yes, how long:		
EXERCISE (TIMES PER WEEK)					
Cardiovascular (walking, running, swimming for ~30 mins)	❑ 0	❑ 1-2	❑ 3-4	❑ 5-6	❑ most days
Strengthening (weight lifting)	❑ 0	❑ 1-2	❑ 3-4	❑ 5-6	❑ most days
Flexibility (yoga, stretching)	❑ 0	❑ 1-2	❑ 3-4	❑ 5-6	❑ most days
Balancing (tai chi, dance, swiss ball)	❑ 0	❑ 1-2	❑ 3-4	❑ 5-6	❑ most days
Most common exercise activities:					
How are most of your days spent?	❑ Standing	❑ Sitting	❑ Walking	❑ Other:	
SLEEP					
Rate your sleep, hours per night:	❑ 4-6	❑ 6-8	❑ 8-10	❑ 12+	
Do you wake rested?	❑ Yes	❑ No			
Do you feel that you are always tired?	❑ Yes	❑ No			
MISCELLANEOUS					
Date of last dental examination?					
Date of last eye examination?					
Date of last medical/physical examination? Blood work results:					

HAVE YOU			If yes, briefly explain
Had a broken bone?	❑ Yes	❑ No	
Had strains or sprains?	❑ Yes	❑ No	
Been struck unconscious?	❑ Yes	❑ No	
Had surgery?	❑ Yes	❑ No	
Used a cane, crutch, or other support?	❑ Yes	❑ No	
Used orthotics, heel lifts, inner soles?	❑ Yes	❑ No	

Do you take vitamins, herbs, or minerals?

List any medications you are currently taking:

Do you have any allergies (to food, drugs, environment)? If yes, please list:

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HEALTH	
Name:	Today's Date (mm/dd/yyyy):

FAMILY HISTORY			
❑ Arthritis	❑ High Cholesterol	❑ Genetic Problems	❑ Hypothyroidism
❑ Auto Immune Condition	❑ Heart Attack	❑ Cancer	❑ Hyperthyroidism
❑ High Blood Pressure	❑ Stroke	❑ Diabetes	❑ Vascular Problems
Not on list:			
CHILDHOOD CONDITIONS (please check everything you have had)			
❑ Measles	❑ Mumps	❑ Chicken Pox	❑ Whooping Cough
❑ Scarlet Fever	❑ Diphtheria	❑ Rheumatic Fever	❑ Typhoid Fever
❑ Ear Infection	❑ Tubes in Ears	❑ Chronic Illness	❑ Asthma
Not on list:			

OTHER
Please list any other information that we should be aware of:

Signature	Date