

# PATIENT INFORMATION RECORD

The information you provide is for the CONFIDENTIAL USE of this office and will only be released with your written consent

Date \_\_\_\_\_ AB Health Care# \_\_\_\_\_ Date of Birth(yy/mm/dd) \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City/Prov \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone: Home/Cell \_\_\_\_\_ Office \_\_\_\_\_

E-mail Address \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_ Referred By: \_\_\_\_\_

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What is your present health complaint that brought you to this office? \_\_\_\_\_

List area(s) of concern: \_\_\_\_\_

When did your condition begin? \_\_\_\_\_ Have you ever had a similar problem? ( ) Yes ( ) No

Have you had X-rays, MRI or other tests taken for this condition? ( ) Yes ( ) No

By Whom? \_\_\_\_\_ Date \_\_\_\_\_ Which Test \_\_\_\_\_

Is this a work related injury? ( ) Yes ( ) No Has your employer been notified? ( ) Yes ( ) No

Is this a Motor Vehicle Accident (MVA)? ( ) Yes ( ) No Date of accident \_\_\_\_\_

Can you perform daily home activities? ( ) Yes ( ) Yes, but only with help ( ) Not at all

Can you perform your daily work activities? ( ) All activities ( ) Only some activities ( ) Not at all

Describe your stress level? ( ) None ( ) Mild ( ) Moderate ( ) High

Do you exercise? ( ) Daily ( ) Occasionally ( ) Not at all What kind of exercise do you do? \_\_\_\_\_

List all previous surgeries, illnesses, injuries (including MVA), current medications: \_\_\_\_\_

Have you had previous Chiropractic care? ( ) Yes ( ) No Because of this condition? ( ) Yes ( ) No

Have you had a massage before? ( ) Yes ( ) No For relaxation or therapeutic? \_\_\_\_\_

Are you seeking: ( ) Chiropractic ( ) Active Release ( ) Graston Technique ( ) Massage Therapy ( ) Unsure

Do you have private/extended/work health insurance? ( ) Yes ( ) No

Ins Co. Name: \_\_\_\_\_

Please indicate all conditions you have experienced. Mark C for current or P for past.

**Joint/Soft Tissue Discomfort:**

- Arms
- Upper Back
- Mid Back
- Lower Back
- Degenerative Discs
- Feet
- Hands
- Hips
- Jaw
- Knees
- Legs
- Neck
- Osteoarthritis
- Rheumatoid Arthritis
- Fractures
- Sciatica Limitation of Movement
- Shoulders
- Pain/numbness down arms or legs
- Pain between shoulders
- Swollen joints
- Spinal curvature

**Skin:**

- Rashes
- Itching
- Bruise Easily
- Dryness
- Boils
- Other \_\_\_\_\_

**Reproductive:**

- Pregnant Weeks: \_\_\_\_\_
- Painful Menstruation
- Heavy Flow
- Irregular Cycle
- Swollen/Lumps Breasts
- Menopausal
- Pre-menopausal
- Post-menopausal
- Birth Control Type: \_\_\_\_\_
- Miscarriages /Complicated pregnancy

**General Symptoms:**

- Fainting
- Dizziness
- Sleep disturbance
- Fatigue
- Nervousness
- Sudden Weight Loss/Gain
- Numbness
- Tingling
- Paralysis
- Headaches (Tension)
- Migraines
- Fever
- Sweats

**Cardiovascular:**

- High Blood Pressure
- Low Blood Pressure
- Coronary Heart Disease
- Heart Attack
- Phlebitis (inflammation of veins)
- Rapid/Slow beating heart
- Hardening of arteries
- Stroke / CVA
- Pacemaker
- Heart Murmur
- Palpitations
- Varicose Veins
- Swelling of the Ankles
- Poor Circulation
- Palpitations
- Cold hands/feet

**Respiratory:**

- Chronic Cough
- Bronchitis
- Asthma
- Hay Fever
- Difficulty Breathing
- Smoking
- Emphysema
- Pneumonia
- Spitting up phlegm/blood
- Chest pain
- Wheezing

**Infectious:**

- Hepatitis
- Tuberculosis
- HIV Virus
- Herpes
- Cold
- Flu
- Athlete's Foot
- Warts
- Other \_\_\_\_\_

**Digestive:**

- Poor Appetite
- Colitis
- Difficult digestion
- Constipation
- Diarrhea
- Nausea
- Ulcer
- Vomiting
- Heartburn
- Blood in stool
- Gallbladder/jaundice

**Eye, Ear, Nose, Throat:**

- Glasses or Contacts
- Hearing Aid
- Hearing Loss
- Sinus Infection
- Swollen Glands
- Allergies
- Frequent Colds
- Eye pain/Db. vision
- Ringing in ears
- Deafness
- Nosebleeds
- Trouble swallowing
- Hoarseness
- Nasal drainage
- Enlarged glands

**Genitourinary**

- Frequent/painful urination
- Blood/puss in urine
- Kidney infection
- Prostate trouble
- Uncontrollable urination

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Indicate the severity of the pain by circling a number.

0 1 2 3 4 5 6 7 8 9 10

No Pain

Extreme Pain

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