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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Please read carefully, and sign.

- The information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is **confidential** and will not be released without my written consent.
- I consent to chiropractic or therapeutic massage treatment by Soft Tissue Rehab Centre
- I understand that **24 hour's notice is required to reschedule** all appointments, or full charges will apply.

_____ _____

Signature Date

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