Westside Chiropractic

NAME	PROVINCIAL HEALTH NUMBER
DATE OF BIRTH	AGE
ADDRESS	CITY/TOWN
PHONE (C) _____ (W) _____ EMAIL	POSTAL CODE OCCUPATION

Is this a work-related injury that may involve WCB? N Y Does this visit involve SGI? N Y Claim Number _____

Current Medical Doctor _____

HEALTH INFORMATION

Reason for your clinic visit today? _____

When did this discomfort initially present? _____ What brought this discomfort on? _____

Have you seen any other health care professionals for this discomfort? N Y If yes, describe _____

Have you had: X-rays? N Y Date & findings _____
CT? N Y Date & findings _____
MRI? N Y Date & findings _____

Is this discomfort interfering with: Work? N Y Daily Routine? N Y

Do you sleep well? N Y Circle sleep position: Side Back Stomach Are you pregnant? N Y

Any personal injury or motor vehicle collision? N Y Date and nature of injury _____

Any surgery? N Y List _____ Any medical conditions? N Y List _____

Any hardware (plates, pins, screws)? N Y Location _____

List your prescribed and non-prescribed medications _____

Do you participate in regular exercise? N Y Examples of your physical activities _____

Alcohol /day _____ Coffee/Tea/Cola /day _____ Tobacco /day _____

Any unexplained weight change? N Y Height _____ Weight _____

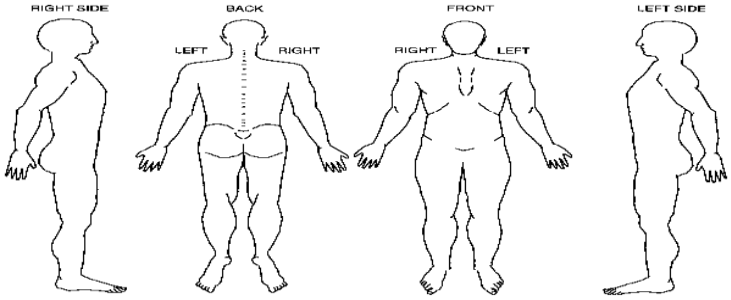
Have you been treated by a Chiropractor in the past? N Y Dr _____

REVERSE →

Using the chart below, indicate any health conditions in your family:

FAMILY	AGE	HEALTH ISSUES
Father		
Mother		
Brother(s)		
Sister(s)		

Using the body diagrams, mark the areas of discomfort:



Circle the words that describe the discomfort:

Dull Ache Stiff Tight

Sharp Numb Burning

Electric Tingling Throbbing

Circle the number(s) that represent the general intensity of your discomfort at its best & worst:

0 1 2 3 4 5 6 7 8 9 10

No Pain Severe Pain

CIRCLE the conditions you PRESENTLY experience and UNDERLINE the conditions you experienced in the PAST:

General Symptoms
Fever
Weakness
Nervousness
Night Sweats

Endocrine
Diabetes
Thyroid

Cardiovascular
Stroke
Chest pain
Heart disease
Varicose veins
Ankle swelling
Atherosclerosis
Bleeding disorder
High blood pressure
Elevated cholesterol

Neurological
Dizzy
Fainting
Seizure
Clumsy
Headaches
Concussion
Cold hands or feet
Numbness or Tingling

Muscles & Joints
Joint Pain
Stiffness
Swelling
Redness
Arthritis
Fractures
Foot discomfort
Spinal curvature

Respiratory
Asthma/COPD
Emphysema
Chronic cough
Spitting up blood
Spitting up mucus
Shortness of breath

Genitourinary
Bedwetting
Blood in urine
Prostate issues
Kidney/Bladder infection
Frequent urination
Bladder control
Urination - painful, difficult

Gastrointestinal
Ulcers
Nausea
Vomiting
Jaundice
Gallbladder
Hemorrhoids
Poor appetite
Stomach pain
Bowel control
Excessive gas
Excessive hunger
Constipation/Diarrhea

Eyes, Ears, Nose, Throat
Vision - double or blurred
Eye pain
Hearing - ring/buzz, loss of hearing
Ear pain
Nose - loss of smell
Throat - pain, hoarseness
Sinus infections
Enlarged glands
Seasonal allergies
Difficulty speaking or swallowing

For Women
Irregular cycle
Breast lumps
Cramps/Backache
Painful menstruation
Menopausal symptoms

Is there anything concerning your health history that has not been asked? _____