I UNDERSTAND THAT I WILL BE CHARGED A $75.00 FEE FOR ANY APPOINTMENT MISSED WITHOUT NOTICE OR WITHOUHT A MINIMUM OF 24 HOURS NOTICE

CASE HISTORY

I understand that the information I give on this form will be confidential. Date: ___________________

Patient Name: _______________________________ Family Doctor: _________________________

Patient Address: _____________________________ Address: ______________________________

City: ________________ Postal Code: ___________ Phone: ________________________________

Telephone(day): _________________ Evening: ______________

D.O.B. _____________________ Wt: __________ Hgt: _________ Occupation: _______________________

How did you hear about our clinic? (Please be specific e.g.: flyer, friend, internet): _______________________

1. General Health (Please describe): ____
   ____
2. Primary Complaint: ____
3. What type of pain? (circle) dull, sharp, local, wide spread, shooting, throbbing
4. Other areas of concern? ____
   ____
5. When did you first notice major complaint? ____
6. What brought it on? ____
7. What activities aggravate the condition? ____
8. Is this condition getting progressively worse? ☐Yes ☐ No ☐ Constant ☐ Comes & goes
9. Is this condition interfering with your work? ________ Sleep? _______ Daily Routine? __________
10. What do you believe is the source of the problem? _____________________________________
11. What have you done to get relief? ____
12. Has there been a medical diagnosis? ________ If yes, what was the diagnosis? _______________________
    ____
    Name of Diagnosing Doctor: ____
    X-rays: ____________________________ Medication for above condition: _______________________
13. Have you had a similar problem before? ☐Yes ☐No If yes, when? _______________________________
    What caused these episodes? ______________________ What relieved them? _______________________
    Previous presentation and treatment: ____
    ____
    Name of attending physician: _________________________________ Phone: _______________________
    Address: ____
14. Do you currently take any medications for any condition ☐ Yes ☐ No
    If yes, please list and indicate what they are for: ____
    ____
15. Have you had any traumatic injuries (i.e. car accidents, falls, etc.) ☐ Yes ☐No If yes, please indicate:
    ____
    ____

Name: ________________________________ Date of birth: ______________________

Please check all the symptoms you are experiencing and add any not mentioned which are significant to you. sometime a symptom, which may seem trivial, can supply a key to providing relief.

HEAD

- ☐ Headache
  - Type: _____________________
  - Frequency: _________________
- ☐ Injury (head)
  - Details: _____________________
  - ____________________________
- ☐ Vertigo
- ☐ Vision Loss
- ☐ Earache
- ☐ Jaw Pain/TMJ dysfunction
- ☐ Sinus
- ☐ Hearing loss
- ☐ Other: _____________________

SKIN

- ☐ Rashes
- ☐ Sores
- ☐ Itching
- ☐ Dryness
- ☐ Herpes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Cold sores
- ☐ Scars
- ☐ Other: ____________________
  ____

DIGESTIVE/UROGENITAL

- ☐ Poor appetite
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Kidney/bladder/liver/gallbladder disease
- ☐ Difficult digestion
- ☐ Diabetes
  - Type: ___________________
  - Onset: __________________
- ☐ IBS
- ☐ Colitis
- ☐ Other: ____________________
  ____

RESPIRATORY

- ☐ Chronic Bronchitis
- ☐ Tuberculosis
- ☐ Frequent colds
- ☐ Shortness of breath
- ☐ Sinusitis
- ☐ Asthma emphysema
- ☐ CCHF
- ☐ Other: _____________________
- ☐ ___________________________

NEUROLOGICAL

- ☐ Fainting spells
- ☐ Blackouts
- ☐ Seizures
- ☐ Paralysis
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors
- ☐ Loss of sensation
  - Where? ___________________
- ☐ Other: ____________________
  ____

VASCULATURE

- ☐ Leg cramps
- ☐ Varicose veins
- ☐ Poor circulation
- ☐ Phlebitis
- ☐ Raynaud's syndrome
- ☐ Arthrosclerosis
- ☐ Other: ____________________
  ____

WOMEN

- ☐ Menstrual problems
  - ☐ Painful
  - ☐ Heavy
  - ☐ Light
- ☐ Pregnant/Due date ___________
- ☐ No. of children ______________
- ☐ History of miscarriages
- ☐ Menopause
- ☐ Hysterectomy
- ☐ Breast cancer
- ☐ Other: _____________________
  ____

CARDIAC

- ☐ Presence of pace maker
- ☐ Heart disease
- ☐ High blood pressure
  - How long? _________________
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Stroke/CVA
- ☐ Heart murmur
- ☐ Angina
- ☐ Other: ____________________
  ____

ARTHRITIS

- ☐ Rheumatoid
- ☐ Osteoarthritis
- ☐ Systemic Lupus Erythematosus
- ☐ Psoriatic
- ☐ Reiter's disease
  - When diagnosed? ___________
  - List affected areas: __________
  ____
  ____
- ☐ Other: ____________________
  ____

Name: ________________________________ Date of birth: ______________________

MUSCLE/JOINTS	Current pain/stiffness	Previous pain/stiffness
Neck	☐	☐
Low back	☐	☐
Mid back	☐	☐
Upper back	☐	☐
Shoulders	☐	☐
Leg: left / right	☐	☐
Knee: left / right	☐	☐

Other: ____

Presence of:
- ☐ Pins
- ☐ Wires
- ☐ Artificial joints
- ☐ Special equipment
- ☐ Screws
- ☐ Plates
- ☐ Other: ____________________

____

CURRENT INVOLVEMENT IN TREATMENT WITH OTHER PRACTITIONER(S)	Yes	No
Chiropractic	☐	☐
Psychotherapy	☐	☐
Personal Trainer	☐	☐
Physiotherapy	☐	☐
Previous massage	☐	☐
Acupuncture	☐	☐
Naturopathic/homeopathy	☐	☐
Osteopathy	☐	☐
Good sleeping patterns	☐	☐
Regular eating habits	☐	☐

Other: ________________________

OTHER CONDITIONS
- ☐ Insomnia
- ☐ Cancer
- ☐ Epilepsy: what type? __________________
- ☐ HIV: How long? _____________________
- ☐ Allergies: __________________________
- ☐ Thyroid imbalance
- ☐ Hepatitis B, C (circle)
- ☐ Psychological
- ☐ Hemophilia
- ☐ Infectious Skin Conditions
- ☐ Osteoporosis

SURGERY

Type: ____ Date: ________________________

Type: ____ Date: ________________________

Type: ____ Date: ________________________

OTHER MEDICAL CONDITIONS: (Self or family history)

____

____

____

____

Name: _________________________________ Date of birth: ______________________