Wetaskiwin Family Chiropractic
Complete Lifestyle and Alternative Healthcare

Welcome

ABOUT YOU

Today's Date: _____ Name: _____
Date of Birth: mm/dd/yyyy _____ Age: _____ ☐ Male ☐ Female
Alberta Health Care Number: _____
Alberta Blue Cross ID Number: _____ Group Number: _____
Address: _____ City: _____ Province: _____
Postal Code: _____ E-mail: _____
Phone: (H) _____ (Bus/Cell) _____
Occupation: _____ Employer: _____
Emergency Contact: _____ Phone: _____
Name & Relationship

REASON FOR VISIT

What is your main reason for contacting us? _____
When did this condition begin? _____
List other care undergone for this complaint, including medication: _____
Other health concerns: _____ Height: _____ Weight: _____
Are you pregnant? ☐ Yes ☐ No Do you have any allergies? _____
Do you have a medical doctor? ☐ Yes ☐ No
Is this a work related injury? ☐ Yes ☐ No Is this injury related to a motor vehicle accident?
Have you previously received chiropractic care at another clinic? ☐ Yes ☐ No
If Yes, please provide: Location of Clinic _____ Name of Clinic _____
How did you hear about our clinic? ☐ Phonebook ☐ Passing By ☐ Friend
☐ Relative ☐ Other _____

Have You Ever?		**If Yes, please explain**
Had a broken bone?	☐ Yes ☐ No	_____
Had surgery?	☐ Yes ☐ No	_____
Had an major illness?	☐ Yes ☐ No	_____
Been hospitalized?	☐ Yes ☐ No	_____
Had strains or sprains?	☐ Yes ☐ No	_____
Used a cane, crutch or support?	☐ Yes ☐ No	_____

Are You Currently Taking Any?		**If Yes, please explain**
Prescription Medication?	☐ Yes ☐ No	_____
Vitamins/Minerals/Herbs?	☐ Yes ☐ No	_____
Over-the-counter medications	☐ Yes ☐ No	_____

ADDITIONAL HEALTH INFORMATION

Please check any of the following you have had in the last six months:

☐ Headaches
☐ Abdominal Cramps
☐ Ear Aches
☐ Poor/Excessive Appetite
☐ Lung Problems
☐ Discoloured Urine
☐ Prostate/Sexual Dysfunction
☐ Menstrual Cycle Dysfunction
☐ Frequent Nausea/Vomiting
☐ Vision Problems
☐ Diarrhea
☐ Heart Problems
☐ Excessive/Painful Urination
☐ Ankle Swelling
☐ Cancer
☐ Sinus Congestion/Allergies
☐ Constipation
☐ Dizziness
☐ Excessive Thirst
☐ Blood Pressure Problems
☐ Diabetes
☐ Difficulty Swallowing

ADDITIONAL HEALTH INFORMATION

When did you last have?	NEVER	0-6 MOS	6-18 MOS	LONGER
X-rays	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐

Dietary Habits:	NONE	LIGHT	MODERATE	HEAVY
Fruits & Vegatables	☐	☐	☐	☐
Whole Grains/Fiber	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Other Sugar Products	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐

Describe your sleep: _____

Describe your weekly physical activity: _____

Complaint, Injury and Symptom Description:

(please circle the appropriate descriptors for your specific area(s) of complaint)

	Pain Is	Pain Quality	Pain Severity	Pain Is Worse	Condition Began
NECK	Constant Frequent Intermittent Occasional Worse On Right/Left	Dull Burning Sharp Stiff Radiating	10 8 6 4 2 0	Morning Evening During Activity Sitting Standing Wakes at night	
MIDDLE BACK	Constant Frequent Intermittent Occasional Worse On Right/Left	Dull Burning Sharp Stiff Radiating	10 8 6 4 2 0	Morning Evening During Activity Sitting Standing Wakes at night	
LOW BACK	Constant Frequent Intermittent Occasional Worse On Right/Left	Dull Burning Sharp Stiff Radiating	10 8 6 4 2 0	Morning Evening During Activity Sitting Standing Wakes at night	
HEADACHES	Constant Frequent Intermittent Occasional Worse On Right/Left	Dull Burning Sharp Stiff Radiating	10 8 6 4 2 0	Morning Evening During Activity Sitting Standing Wakes at night	
SHOULDERS	Constant Frequent Intermittent Occasional Worse On Right/Left	Dull Burning Sharp Stiff Radiating	10 8 6 4 2 0	Morning Evening During Activity Sitting Standing Wakes at night	
OTHER SPECIFIC AREA	Constant Frequent Intermittent Occasional Worse On Right/Left	Dull Burning Sharp Stiff Radiating	10 8 6 4 2 0	Morning Evening During Activity Sitting Standing Wakes at night	

Briefly describe any treatment you have received for these symptoms and the result of this care: _____