AVORD CHIROPRACTIC • Millar • White • Debusschere

PERSONAL INFORMATION & MEDICAL HISTORY FORM

Please provide as much of the following information as possible.

Your medical history and other health information is held under the highest level of confidentiality and will be released only with your consent or in the unlikely event that it is required by law.

Name _____ **Date** _____

Address _____
Apt. or House # Street City Postal Code

Telephone _____ (Home) **Date of Birth** _____
_____ (Work) **Health Number**_____
_____ **(Cell)**

Occupation _____ Employed by _____

Employer Address _____

Marital Status ***(optional)***: 0 Single 0 Married/Partnered 0 Widowed
Spouse/Partner Name ***(optional):*** _____

If you will be claiming your chiropractic treatment under any of the following, Please check the appropriate box:

0 **Workers Compensation (WCB)** 0 **SGI** 0 **RCMP** 0 **Family Health Benefits**
Claim Number _____ Contact Person _____

Have you seen a Chiropractor before? 0 Yes 0 No

• **Kindly Note*: You are invited to discuss any concerns or questions about chiropractic treatment with your Chiropractor and are welcome to take informative pamphlets available at the front desk*** •

If yes, which Chiropractor and from what city? _____

Name of Family Practitioner _____

Person recommending you to Avord Chiropractic _____
Have you had any X-rays, MRI, or CT Scan on the area in question ( ) Yes ( ) No
Where _____

PLEASE ANSWER THE FOLLOWING QUESTIONS SO WE MAY HAVE THEM FOR YOUR FILE:

Current Reasons for Chiropractic Treatment:

1. What physical concern/problem prompted you to come to the Chiropractor?
   _____
2. How long ago did this particular physical concern or pain begin?
   _____
3. What were you doing at the time that might have caused the problem?
   _____
4. Please list the things that make your problem worse or increase your pain:
   _____
5. Please list the things that help or ease the pain:
   _____

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Past incidents that help us understand the present:

6. Have you had any similar conditions in the past? 0 Yes 0 No
   If yes, please state when and provide details where possible: _____

   _____

7. In the past, have you been in an accident (car, fall, work, etc.)? 0 Yes 0 No
   If yes, please list all the incidents and dates as best as you can remember.

   _____

8. What kind of treatment did you receive for these incidents? *With this, please note any of the practitioners that you remember.* _____

9. Have you ever been treated for any of the following:

0 Arthritis	0 Diabetes	0 Gallbladder	0 Kidney Problems
0 Asthma	0 Disc	0 Gout	0 Liver Disease
0 Bursitis	0 Dizziness	0 Headaches	0 Nerves
0 Cancer	0 Epilepsy	0 Heart Problems	0 Rheumatic Fever
0 Tuberculosis	0 Ulcers	0 High Blood Pressure	0 Skin Disease

10. Please list all surgeries: _____

Present medical treatment and conditions:

11. Are any other practitioners treating you for this pain/condition? 0 Yes 0 No
    If yes, please explain: _____

    _____

12. Are you being treated for ***other*** health conditions? 0 Yes 0 No
    If yes, please list any current conditions for which you are being treated.

    _____

13. Are you currently taking any medications? 0 Yes 0 No
    Please list any current medications you are taking: _____

    _____

14. Are you undergoing Physiotherapy or Exercise Therapy? 0 Yes 0 No

    Therapist and Clinic: _____

15. Do any of your health concerns wake you from a sound sleep? . . . 0 Yes 0 No
16. Are you experiencing unintentional weight loss? 0 Yes 0 No
17. Are you finding blood in your urine or stool? . . . . . 0 Yes 0 No
18. Are you finding any blood in your cough? 0 Yes 0 No
19. Are you experiencing loss of bowel or bladder control? . . . . . 0 Yes 0 No
20. Have you lost consciousness or had double vision? ……. 0 Yes 0 No
21. Have you noticed new lumps or moles on your skin? Changes? . . . 0 Yes 0 No
22. Do you have hoarseness or a cough that won't go away? 0 Yes 0 No
23. Do you have indigestion or difficulty with swallowing? . . . . . 0 Yes 0 No
24. Do you have any symptoms or health problems that you have not previously mentioned on these forms? *Please Mention*: _____ 0 Yes 0 No

    _____

25. Please list all allergies: _____

26. **Women Only:** Could there be a chance that you are pregnant? 0 Yes 0 No