NEW PATIENT INFORMATION

PERSONAL INFORMATION

Name:_____ Hm#:_____ Wk#:_____ Cell#:_____
Address:_____ Postal Code:_____
Birth Date: Month_____ Day_____ Year_____ Age:_____ Sex: M / F
E-Mail:_____ Occupation:_____
Sask Health Care #:_____
Do you have health care benefits for chiropractic? ☐ Yes ☐ No
Who can we thank for referring you to our office?_____ ☐ Internet ☐ Walk-in
Is this injury the result of a motor vehicle accident, or a work related accident?
If Yes, please list:_____
Have you had previous Chiropractic care? ☐ Yes ☐ No Doc's Name:_____ How long ago?_____
Have you received x-rays in the last 2 years?? ☐ Yes ☐ No Area x-rayed:_____
Name of Family Medical Doctor:_____ Others seen for this condition:_____

PLEASE CHECK ANY OF THE FOLLOWING THAT CURRENTLY APPLY TO YOU AND ELABORATE IF NEEDED:

☐ Nausea	☐ Back Pain	☐ Neck Pain	☐ Poor Concentration	☐ Allergies
☐ Fevers	☐ Difficult Digestion	☐ Dizziness/Vertigo	☐ ADD/ADHD	☐ Asthma
☐ Sweats	☐ Difficult Urination	☐ Eye Pain	☐ Panic Attacks	☐ Hearing Problems
☐ Nervousness	☐ Menstrual Pain	☐ Shoulder/Arm Pain	☐ Anxiety	☐ High Blood Pressure
☐ Loss of Sleep	☐ Irregular Cycle	☐ Wrist/Hand Pain	☐ Depression	☐ Diabetes
☐ Loss of Weight	☐ Decreased Libido	☐ Heartburn	☐ Chronic Fatigue	☐ Hypoglycemia
☐ Fainting	☐ Kidney Problems	☐ Dry eyes/mouth	☐ Loss of Taste/Smell	☐ Hot Flashes
☐ Chest Pain	☐ Prostate Problems	☐ Sinus Problems	☐ Seizures	☐ Menstrual Symptoms
☐ Difficult Breathing	☐ Arthritis	☐ Ringing in Ears	☐ TMJ/Jaw Pain	Numbness/Tingling in:
☐ Heart Palpitations	☐ Knee/Foot Pain	☐ Headaches	☐ Auto-immune	☐ Arms ☐ Hands
☐ Low Energy	☐ Cold Hands/Feet	☐ Migraines	☐ Fibromyalgia	☐ Legs ☐ Feet

YOUR INJURY HISTORY

1. What is your major reason for consulting our office?_____
2. How long has this been going on for? ☐ Days ☐ Weeks ☐ Months ☐ Years
3. What specific activities does this interfere with? (work, sleep, leisure…)_____
4. How did it originally occur?_____
5. Has it become worse recently? ☐ Yes Explain:_____
   ☐ No ☐ Same ☐ Better ☐ Gradually worse
6. How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night only
7. Is there anything you have done to relieve this? ☐ Yes ☐ No
   If yes, explain:_____
   If no, what have you tried that does not work?_____
8. What makes this condition worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting
   Other:_____
9. Describe the pain: ☐ Sharp ☐ Dull ☐ Numb ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing
   Other:_____
   Does the pain travel or radiate? ☐ Yes ☐ No If Yes, where?_____
10. Are there other unrelated health problems? ☐ Yes ☐ No If Yes, describe:_____
    _____
11. Have you had any broken bones? ☐ Yes: _____ ☐ No

12. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or present? ☐ No ☐ Yes: _____
13. To your knowledge is there a family history of cancer, stroke, diabetes, heart disease, or a spinal condition? ☐ No ☐ Yes, explain:_____
14. Please list any medications that you are currently taking:_____
_____

Please place an "X" on the line below to indicate the level of the problem:

NO EXTREME
SYMPTOMS 0 |----------|10 SYMPTOMS

YOUR HEALTH PROFILE

Spinal subluxations have a significant impact on your health and well-being. Please answer the following important questions to the best of your ability and in as much detail as possible.

Physical Stress

☐ Yes ☐ No Have you ever been involved in a motor vehicle accident (even if you were not injured)
If Yes, explain:_____
☐ Yes ☐ No Have you had any falls or accidents? (Hard falls, sports/car/life accidents, concussions, etc)
If Yes, please list:_____
☐ Yes ☐ No Do you currently play any sports? If Yes, please list:_____
☐ Yes ☐ No Have you had any sports injuries? If Yes, please list:_____
☐ Yes ☐ No Were you under regular Chiropractic care as a child?
☐ Yes ☐ No Does your job require lifting, repetitive motions, excessive sitting or standing still? (circle)
☐ Yes ☐ No Have you had any surgeries? If Yes, please list:_____

Chemical Stress

☐ Yes ☐ No Do/did you smoke? How many per day?_____
☐ Yes ☐ No Do/did you drink alcohol? How many per week?_____
☐ Yes ☐ No Do you drink coffee? How many per day?_____
☐ Yes ☐ No Do you drink pop? How many per week?_____
☐ Yes ☐ No Do you eat out frequently or eat large amounts of junk food?

Please list all drugs you are currently taking (prescription, non-prescription, otherwise):_____
_____

Emotional Stress

On a scale of 1 (best/least) to 10 (worst/most), rate your current stress level of the following:
Work_____ Home_____ Financial_____ Other_____
Please rate the following as either poor, fair, good, or excellent:
Diet_____ Exercise_____ Sleep_____ General Health_____

☐ Please sign me up to receive emails from InBalance Chiropractic regarding weekly newsletters, special promotions, the latest health information, exercises, and recipes.

If you are unable to attend your appointment, please give our office a call to reschedule. **Missed appointments are subject to a $40 fee.**

Patient Signature_____ Date:_____

Doctor's Signature_____ Date:_____