Natural Path Wellness Centre - Chiropractic Forms

Patient Information

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Business/Employer: _____ Type of Work: _____

Work Phone: _____

Birth date:_____ Age: _____ Preferred Pronouns: _____

Circle one: Married Single Widowed Divorced Separated Other

Number of Children: _____

Emergency Contact: _____ Phone Number: _____

Relationship: _____

How were you referred to this office?

_____

Insurance Information

Provincial Health Card #: _____

Extended Health Care Company: _____

Policy#_____ ID#_____

Is current condition related to a:

_____ Motor Vehicle Accident

_____ Work Related Injury

If yes to either enter claim information below:

_____

Current Health Condition

Current Complaint(s): _____

Other doctors seen for this condition? ☐☐Yes ☐ No Who? _____ Type

Of Treatment: _____ Results: _____

When did this condition begin? _____

Has this condition occurred before? _____

Is the condition: ☐ Job-related ☐Auto-related ☐ Home Injury ☐ Fall

☐ Other: _____

Date of accident: _____ Time of Accident: _____

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking

Lying Down ☐ Cold ☐ Dampness ☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication

Other: _____

Is it getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes/Goes

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning

☐ Constant ☐ Intermittent ☐ Other: _____

Place and X on the grade to indicate the severity of your pain:

Least 1 2 3 4 5 6 7 8 9 10 Worst

Drugs you take now: ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine

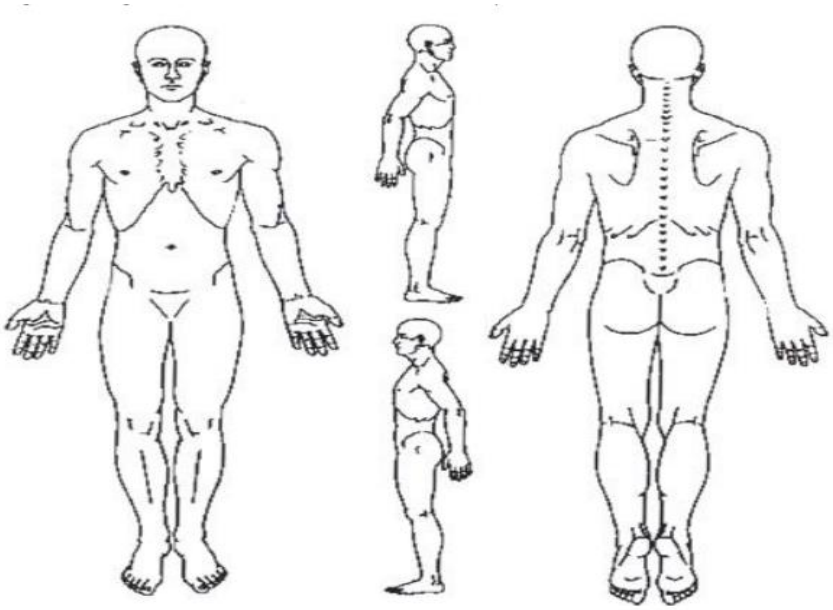
☐ Insulin ☐ Antidepressants/anxiety☐ Other: _____

Do you suffer from any other condition than the one you are now consulting us for?_____

Have you had x-rays taken in the last year? ☐☐ Yes ☐☐ No If yes, where?

_____

Please indicate region of pain on the diagram below:



Past Health History

Major Surgery/Operations: ☐ ☐Appendectomy ☐Tonsillectomy ☐Gall Bladder

☐ Hernia ☐ Back Surgery ☐☐ Broken Bones ☐ Other: _____

Previous: ☐ Childhood Traumas: _____ Sports Injuries: _____

Motor Vehicle Accidents: _____ ☐ Work Injuries: _____

Hospitalizations (other than above):

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name: _____

Approximate Date of Last Visit: _____

Family Health History

Name of Family Physician: _____

Please indicate any health issues that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom?

_____

Below is a list of symptoms/diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

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

Nervous System
□ Nervous
□ Numbness
□ Paralysis
□ Dizziness
□ Forgetfulness
□ Confusion/Depression
□ Fainting
□ Convulsions
□ Cold/Tingling Extremities
□ Stress

Musculo-Skeletal
□ Low Back Pain
□ Gas/Bloating After Meals
□ Pain Between Shoulders
□ Heartburn
□ Neck Pain
□ Black/Bloody Stool
□ Arm Pain
□ Colitis
□ Joint Pain/Stiffness
□ Walking Problems
□ Difficulty Chewing/Clicking Jaw
□ General Stiffness

General
□ Fatigue
□ Allergies
□ Loss of Sleep
□ Fever
□ Headaches

C-V-R
□ Chest Pain
□ Short breath
□ Blood Pressure Problems
□ Irregular Heartbeat
□ Heart Problems
□ Lung
□ Problems/Congestion
□ Varicose Veins
□ Ankle Swelling
□ Stroke

EENT
□ Vision Problems
□ Dental Problems
□ Sore Throat
□ Ear Aches
□ Hearing Difficulty
□ Stuffed Nose

Do you have a regular exercise program?
□ Yes
□ No

Lifestyle Stress Levels
□ High
□ Low

Reproductive System

When was your last period**?**

_____

Are you pregnant?
□ Yes □ No □ Not Sure

Intake
□ Coffee
□ Tea
□ Alcohol
□ Cigarettes

Satisfaction with Diet
□ Highly Satisfied
□ Dissatisfied
□ Highly Dissatisfied