

## CONFIDENTIAL CASE HISTORY

DATE: \_\_\_\_\_

### PERSONAL INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Do you prefer:  First Name  Mr.  Mrs.  Ms.  Miss  Dr.  Other \_\_\_\_\_  
 Birthdate: M: \_\_\_\_ D: \_\_\_\_ Y: \_\_\_\_ Marital Status:  M  S  W  D  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell or Other: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 What Occupies your spare time?: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Children's Names: \_\_\_\_\_  
 Who can we thank for your referral today?: \_\_\_\_\_  
 Name of Family Physician: \_\_\_\_\_

### HEALTH INFORMATION

Have you had previous chiropractic care?  YES  NO When? \_\_\_\_\_ Why? \_\_\_\_\_  
 Have you ever had x-rays?  YES  NO For what reason? \_\_\_\_\_  
 What is your major complaint? \_\_\_\_\_  
 How long have you had this condition? \_\_\_\_\_ Have you had it before?  YES  NO  
 What aggravates your condition? \_\_\_\_\_  
 Is it getting:  Better  Worse  Constant  Comes and goes  
 Is this condition interfering with your:  Work  Sleep  Daily Routine  Other \_\_\_\_\_  
 How long has it been since you really felt good? \_\_\_\_\_  
 Others who treat this condition: \_\_\_\_\_ List any surgeries and dates: \_\_\_\_\_  
 Drugs you are currently taking:  Pain killers  Muscle relaxants  Anti-inflammatories  Birth Control  Other \_\_\_\_\_  
 Are you wearing:  Heel Lifts  Orthotics  Special supports or braces  
 Have you ever had any other personal injury or accident?  YES  NO Describe: \_\_\_\_\_

### REASON FOR CONSULTING THE OFFICE:

- I have a specific problem and only require help with this problem.
- After my problem has been relieved, I am interested in strategies to ensure the problem does not return.
- Spinal checkup and to improve my general health.

**HEALTH HISTORY:**

To provide us with a more complete clinical picture, please answer the following questions, even if you do not think they are related to your health problem.  
Pain is often referred from other areas or it may be related to a more serious underlying pathology.

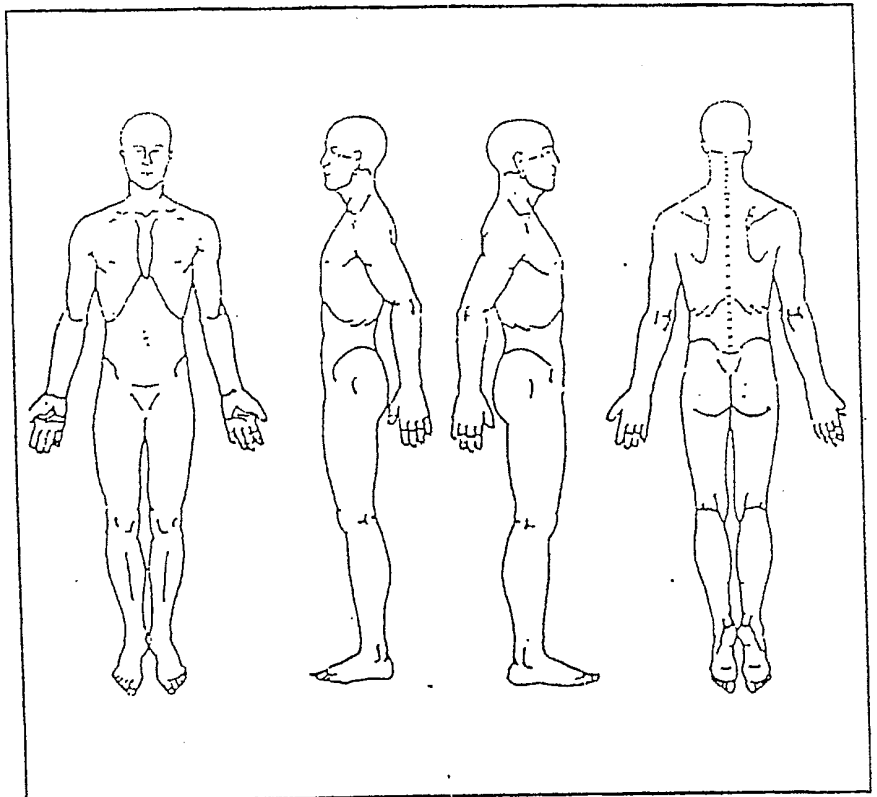
Have you ever suffered from:

Please mark the main areas of pain on the figures below:

- 1. Dizziness  Yes  No
- 2. Heart trouble  Yes  No
- 3. Diabetes  Yes  No
- 4. Arthritis  Yes  No
- 5. Asthma  Yes  No
- 6. Cancer  Yes  No
- 7. Digestive problems  Yes  No
- 8. Numbness  Yes  No
- 9. Tingling  Yes  No
- 10. Bladder trouble  Yes  No
- 11. Kidney trouble  Yes  No
- 12. Backaches  Yes  No
- 13. Neck pain  Yes  No
- 14. Headaches  Yes  No

**FEMALES:**

- 1. Severe menstrual pain  Yes  No
- 2. Vaginal pain  Yes  No
- 3. Breast pain  Yes  No
- 4. Lumps on breast  Yes  No



**FAMILY HEALTH INFORMATION** (Past or present health problems)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

Type of Coverage:  MSP  WCB  ICBC  Other: \_\_\_\_\_

Medical Number: \_\_\_\_\_