

CONFIDENTIAL PATIENT CASE HISTORY

Date _____

E-mail: _____

Name _____

Address _____

Mr. Mrs. Miss. Ms. Dr.

City _____

Province _____ Postal Code _____

Birthdate ____/____/____
day month year

Age _____ Sex: M F

Business/Employer _____

Children? Y N Ages _____

Tel # home _____ work _____ cell _____

Is this a Worker's Compensation case? Y N
 Is this a Motor Vehicle Accident case? Y N

How do you prefer to be addressed?
 (nickname etc?) _____

Family Physician _____

Referred by: Family ___ Friend ___ Who? _____ Yellow Pages ___ Internet ___ Advert ___ Other ___

Present Reason for Consulting the Clinic

List any major symptoms: _____

How long have you had these symptoms? _____ Have you had similar symptoms? Y N

What activities aggravate these symptoms? _____

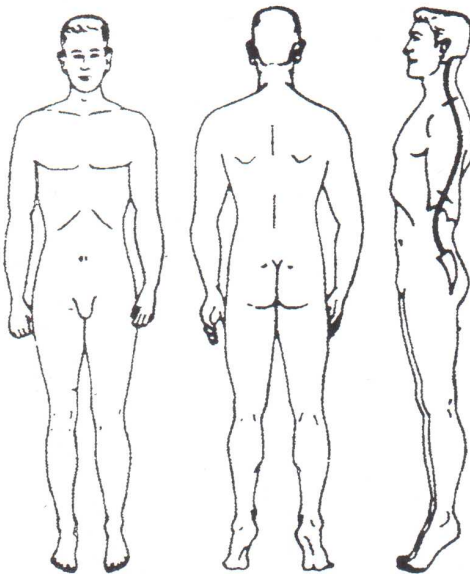
Other health practitioners who treated these symptoms? _____

Other chiropractors who treated these symptoms? _____

Other complaints? _____

Mark your area of pain on picture below.

Date of last: (Please ✓)



	less than 6 months	6-18 mos	over 18 mos	never
spinal exam				
physical exam				
blood test				
urine test				
spinal x-ray				
other x-ray				

Lifestyle Habits

Alcohol - per day _____

Coffee/Tea - per day _____

Smoking - per day _____

Soft drinks - per day _____

Exercise - per week _____ type _____

Sleep: back _____ side _____ front _____

Bed: foam _____ spring _____ waterbed _____ futon _____

Pillows: one _____ two _____ more _____ cervical _____

Medications (Drugs) _____

Vitamins/Minerals/Supplements _____