# ARNPRIOR CHIROPRACTIC HEALTH CENTRE

5 Charles St. Arnprior Ontario, K7S 1A6

Please complete this form as fully and carefully as possible.
Your answers help us determine the true nature of your complaint and how best we may help you.

Name: _____ Gender: M / F Date of Birth:_____ (dd/mm/yyyy)
Home Address:_____ City:_____ Postal Code:_____
Phone: (H)_____ (W)_____ ext._____
Your occupation:_____ What do you do mostly? (sit / stand / etc.)_____
Marital status: S / M / D / W Do you have any children? Y / N Ages: _____
Family Doctor Name & Address:_____
Date of Last Physical Exam: _____ Reason: _____
Have you ever been to a chiropractor before? Y / N Name of chiropractor: _____
For what condition:_____ How long ago: _____

WAS THIS AN INJURY THAT OCCURRED AT WORK? Y / N Was it reported? Y / N WSIB# _____
WAS THIS AN INJURY AS A RESULT OF A CAR ACCIDENT? Y / N Is there a claim pending? Y / N

Please list any significant illnesses or limitations:_____
List any medications or supplements: _____
Do you smoke? Y / N If yes, how much? _____ For how long?_____
List any allergies_____
How would you rate your level of stress? low / med / high
Do you exercise regularly? Y / N What type of exercise? _____
Do you use any devices such as cervical pillows, orthotics, back supports, braces, etc.? Y / N
specify _____
Where do you carry your wallet or purse? over shoulder __ back pocket __ front pocket __ L __ R __ backpack __
What is your daily water intake? _____ 8 oz. glasses
What is your daily intake of caffeinated beverage or soft drink? _____ 8 oz. Glasses

## PLEASE CIRCLE THE FOLLOWING ITEMS THAT APPLY TO YOU

### HEALTH HISTORY

Severe Accidents/falls.....
.....
Hospitalization.....
.....
Surgery.....
.....
Fractures.....
.....
X-rays .....
.....
Unusual weight change .....

### CHILDHOOD ILLNESS

Chicken Pox
Headaches
Measles
Mumps
Rubella
Rheumatic Fever
Whooping Cough
Tuberculosis
Other

### FAMILY HISTORY (parents, siblings, etc.)

Anemia .....
Arthritis .....
Cancer.....
Diabetes .....
Epilepsy .....
Headache/Migraine .....
Heart Disease/hypertension .....
Kidney Disease .....
Mental Illness .....
Stroke .....
Other .....

### DO YOU *CURRENTLY* EXPERIENCE?

| | | | | | | |
|---|---|---|---|---|---|---|
| Chest pain | Cramps | Constipation | Diarrhea | Dizziness | Headache | Fainting |
| Excess Thirst | Fatigue | PMS | Heartburn /Gas | Numbness | Pain | Seizures |
| Spasms | Stiffness | Swelling | Tremor | Vomiting | Weakness | |
| Unusual Bleeding | | Painful Urination | | Frequent Urination | | |

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How did you hear about our clinic? sign outside ___ yellow pages ___ newspaper ad ___ other _____
friend / other client ___ Who? _____
If one of our clients sent you, may we send them a *Thank You* letter? Y / N

Arnprior Chiropractic Health Centre adheres to federal privacy legislation. All information received is strictly confidential and for diagnostic purposes only. If it is necessary to release or obtain any of your health information to further manage your case, your permission will be required.

Patient signature _____ Date _____

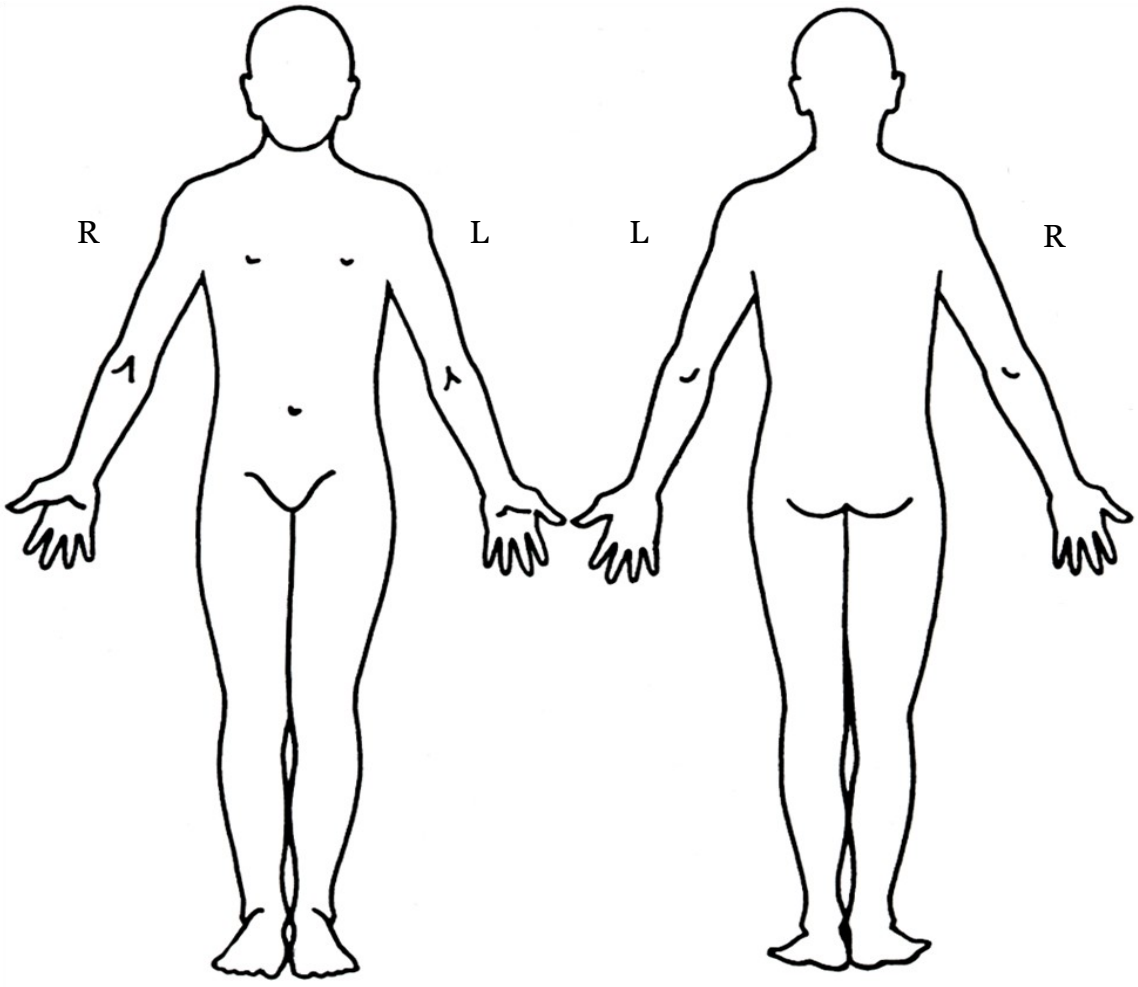
Email address _____

In the diagrams provided below, please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas.

Use the symbols provided below.

**Symbols**:

| | |
|---|---|
| Numbness | ———————— |
| Burning | xxxxxxxxxxxxxxx |
| Dull and aching | ++++++++++++ |
| Pins and needles | ..... |
| Stabbing and sharp | IIIIIIIIIIIIIIIIII |
| Stiff and tight | 222222222222222 |




Front Back

On the line provided, please mark where your "pain status" is today

No pain Most severe pain