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www.family1stchiro.ca

CONFIDENTIAL PATIENT INFORMATION ***Date:*** ______________

Name: ______________________________ Birth Date: YYYY/MM/DD_______/_____/_____
Home Phone: ______________Cell. Phone: ______________AHC#: ______________
Address:______________________City/Town:______________ Prov.:_____Postal Code: __________
Sex: Male Female Preferred ____________Email: ______________________

Appointment reminder: Email ☐ Text ☐ Cellular provider: ____________Remind: _____Day/s before and/or _____Morning of
I consent to electronic communications from Family First **Y or N**

Third Party Insurance: ____________Claim/ID#: ____________Group/Policy: ____________
Employer: ____________Occupation: ______________Married: ___Single: ___Common Law: ___Other: ____
Name of Partner: ______________Occupation: ______________ # of Children? ________
How did you hear about us? Facebook ☐ Twitter ☐ Google ☐ Person ☐ Who may we thank? ____________
Emergency Contact: ______________Phone: ______________ Other: ____________

Female: Are you pregnant? Yes No *Unsure* **Last Day of Cycle**: __________**Weeks:** __________**Due Date:** __________
What is the purpose of your appointment? ______________________________
Date symptoms appeared? ____________ What area? *Neck Mid Back Low Back Hips Other:*__________
Where? *Left Middle Right Front Back Other*______________ How did it start? *Gradually Suddenly*
How would you describe the pain? *Sharp Dull Achy Burning Stabbing Deep Shooting Other*__________
How intense is the pain? *Mild Moderate Severe* ____*/10* Does your condition: *Come and Go* Or is it: *Constant*
What aggravates your condition? *Activity Rest Lifting Occupation Bending Turning Stress Other*__________
What relives your condition? *Activity Rest Ice Heat Standing Sitting Lying Down Other:*______________
Are you experiencing dizziness? *Y N* Nausea? *Y N* Describe (how long, when, ect...): ______________
Is this condition interfering with your: Quality of Life _____Work _____Sleep _____Other: ______________
Describe: ______________________________
Primary Health Care Provider / Clinic: ______________________________
Have you been treated for any health condition in the last year? *Y N* Is this an MVA injury: *Y N* WCB injury: *Y N*
Describe: ______________________________
Date of last physical examination: ____________________Purpose: ______________
What Vitamins are you taking?______________________________
What over the counter medications are you taking? ______________________________
What prescription medications are you taking? ______________________________

Family history of disease (please check all that apply):

Disease/Condition:	X	Family Member Affected:
Heart Attack		
Heart Disease		
Stroke		
Diabetes Mellitus		
Multiple Sclerosis		
Cancer		

Disease/Condition:	X	Family Member Affected:
Osteoporosis		
List all other Diseases/Conditions:		

Past History
What operations have you had? When?______________________________
____
Have you ever been hospitalized?______________ Serious illness? ______________
Have you ever had any bad accidents or falls? *Yes No* If so, when? ______Adult ______Child ______Infant
Broken/Fractured bones? *Yes No* Which ones? ______________________________
Do you have a history of Osteoporosis? Describe ______________________________
Have you ever been under Chiropractic care? *Yes No* Chiropractors Name:__________ Last Adjustment date:__________

What tests/exams have you had done?

Bone Density Test	
MRI	
CT Scan	
X Ray	
Bone Scan	

List all other test/exams

Are You Suffering From or Have You Ever Suffered From:

- ❑ Allergy
- ❑ Dizziness
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of sleep
- ❑ Ulcers
- ❑ Nervousness / Depression
- ❑ Numbness
- ❑ Arthritis
- ❑ Bursitis
- ❑ Foot trouble
- ❑ Low back pain
- ❑ Neck pain or stiffness

Tingling or numbness in:

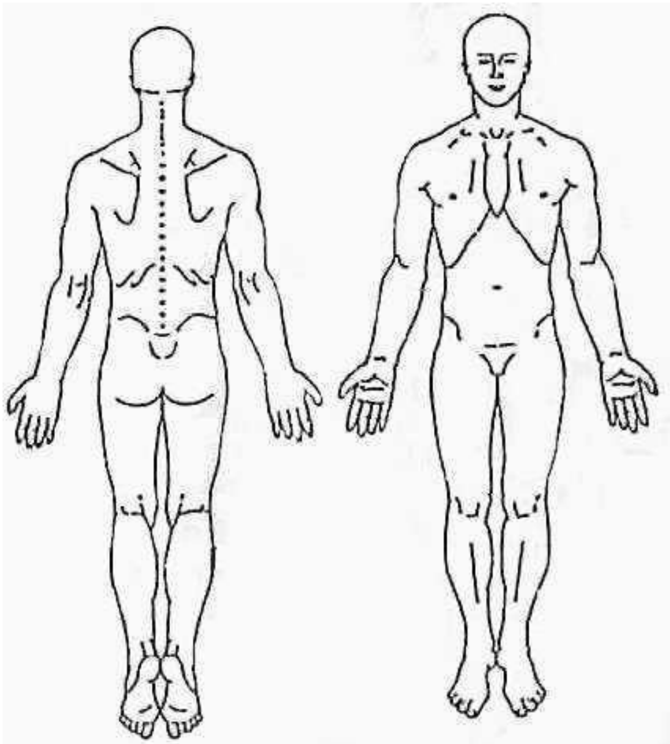
- ❑ Shoulders
- ❑ Arms
- ❑ Elbows
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Feet

- ❑ Poor posture
- ❑ Sciatica
- ❑ Spinal curvatures
- ❑ Swollen joints
- ❑ Colon trouble
- ❑ Diarrhea
- ❑ Difficult digestion
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Asthma
- ❑ Colds
- ❑ Deafness
- ❑ Ear noises
- ❑ Enlarged thyroid
- ❑ Eye pain
- ❑ Failing vision
- ❑ Sexual Transmitted disease
- ❑ Heart disease
- ❑ Concussion/head trauma

- ❑ Tuberculosis
- ❑ Bruise easily
- ❑ Hay fever
- ❑ Nosebleeds
- ❑ Sinus Infection
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Slow heart beat
- ❑ Anemia
- ❑ Stroke
- ❑ Chest pain
- ❑ Difficult breathing
- ❑ Pleurisy
- ❑ Spitting
- ❑ Swelling of ankles
- ❑ Cancer

- ❑ Itching
- ❑ Varicose veins
- ❑ Bed-wetting
- ❑ Frequent urination
- ❑ Kidney infection or stone
- ❑ Prostate trouble
- ❑ Cramps or backache
- ❑ Excessive menstrual flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Lumps in breast
- ❑ Alcoholism
- ❑ Diabetes
- ❑ Polio
- ❑ Aids / HIV positive
- ❑ Hypoglycemia
- ❑ Chronic fatigue syndrome
- ❑ Fibrosis / Fibromyalgia
- ❑ Psoriasis / Eczema

Please shade or circle all areas of complaint.



Habits	Heavy	Moderate	Light	None
Alcohol	_______	_______	_______	_______
Coffee	_______	_______	_______	_______
Tobacco	_______	_______	_______	_______
Exercise	_______	_______	_______	_______
Sleep	_______	_______	_______	_______
Cannabis	_______	_______	_______	_______

Are you Wearing …

Heel Lifts _______

Inner Soles _______

Arch Supports _______

Is there any other information?

____

____

____

____

____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment ____

I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable. We request 24 hours for cancellation of a visit.

Patient's Signature____Date__________________

Guardian or Spouse's Signature Authorizing Care______________________________Date__________________