142 Erickson Drive, Red Deer, Alberta T4R 2C3
Phone: 403.347.3261 Fax: 403.347.3221
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:

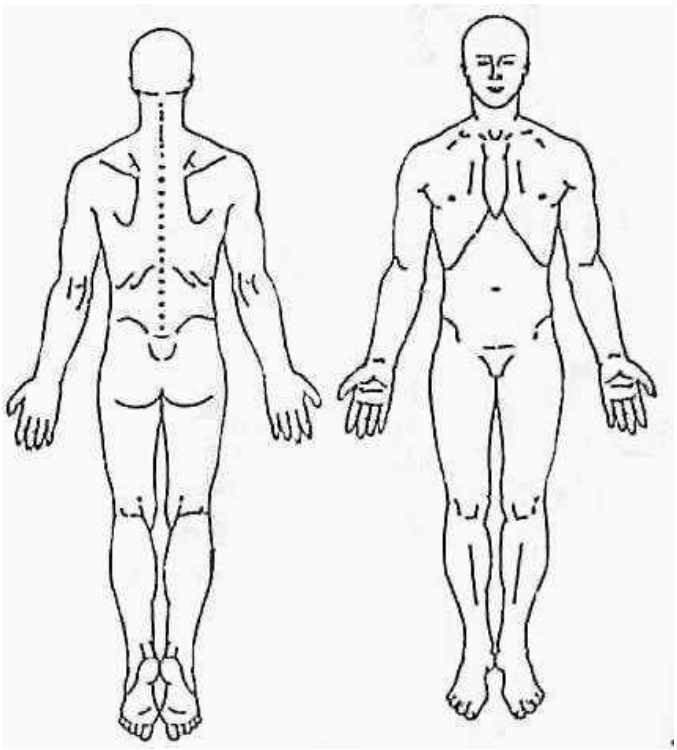
- ❑ Shoulders
- ❑ Arms
- ❑ Elbows
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Feet

- ❑ 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.

I understand that Chiropractic does not treat the disease or symptoms but uses them to ascertain where the specific adjustment(s) are needed. Chiropractic only attempts to adjust vertebrae, restoring the nerve impulses to the involved tissue, thus allowing the body it's best chance of healing itself. I give the doctors and assistants at Family First Chiropractic and Wellness full permission to render care to myself and/or my family.

Patient's Signature_____ Date_____
Guardian or Spouse's Signature Authorizing Care_____ Date_____