Name _____ Occupation _____
Address _____ Marital Status S M D W
City _____ Prov ____ PC _____ Spouse's Name _____
Phone: (H) _____ (W) _____ Number of children _____
E-mail _____ Due Date _____
Date of Birth _____ (Age _____) Referred By _____

Chiropractic History

Have you previously seen a chiropractor? □ Yes □ No Reason _____

Did they take x-rays? □ Yes □ No If yes, when was your last visit_____

Current Health Condition □ *I'm here for wellness and have no complaints (Please skip to the next section)*

Reason for today's visit _____

Pain or problem started on_____ Why do *you* think the problem/pain started? _____

_____

Pain is: □ Sharp □ Dull □ Constant □ Intermittent Pain interferes with: □ Work □ Sleep □ Routine □ Other _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is it worse during certain times of the day? _____

Is this condition getting progressively worse? □ Yes □ No

Other Doctors seen: _____

Any home remedies? _____

Other Symptoms

□ Headaches
□ Neck Pain / stiff
□ Sleeping Problems
□ Back Pain
□ Nervousness
□ Tension
□ Irritability
□ Chest Pains
□ Dizziness
□ Face Flushed
□ Pins & Needles in Legs
□ Pins & Needles in Arms
□ Numbness in Fingers
□ Numbness in Toes
□ Shortness of Breath
□ Fatigue
□ Depression
□ Light Bothers Eyes
□ Double Vision □ Loss of Memory
□ Ears Ring / buzzing
□ Fever
□ Fainting
□ Cold Sweats
□ Loss of Smell
□ Loss of Taste
□ Difficulty Swallowing
□ Diarrhea
□ Feet Cold
□ Hands Cold
□ Stomach Upset
□ Nausea
□ Constipation
□ Loss of Balance
□ Ear Infections
□ Asthma
□ Allergies
□ Frequent colds/flu
□ Thigh Pain
□ Pubic Pain
□ leg / calf cramps □ Multiple Sclerosis
□ IBS / Crohn's disease

Other conditions, diseases or concerns:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Birthing Information

Who are your chosen birth attendants? □ Midwife □ Obstetrician □ Doula □ Chiropractor

Name of birth attendants: _____ Date of last visit: _____

Chosen Location of Birth: □ Hospital □ Birthing Center □ Home

How active is your baby? □ Not moving at all □ slow but moving □ active □ very active □ other _____

If you have had a previous pregnancy, did you have or experience any of the following with your labour:

□ Hospital birth □ home birth □ birthing centre birth □ Other birth location □ Epidural □ episiotomy □ induction
□ breech presentation □ back labour □ forceps □ c-section □ vacuum extraction □ fetal scalp monitoring

Accidents/Trauma/Injury History

Number of car accidents: _____ Approximate dates: _____

Any work, sports or other injuries: _____

Any medications you are currently taking: _____

Have you had surgery? □ Yes □ No What type? _____ When?_____

Any significant family medical conditions/history: _____

Rate your occupational stress (1-10, 10 being the most stressful) _____ Rate your family / life stress (1-10) _____

As a result of my chiropractic care, I would like to: *(Please check all that apply)*

□ Feel better quickly □ Healthier spine and postural alignment □ Better quality of life
□ Prepare my body & pelvis for labor / delivery □ Assist a breech / posterior baby presentation

Signature _____ Date _____