

**WEST LETHBRIDGE FAMILY CHIROPRACTIC
NEW PATIENT FORM**

Name _____ Date _____ Male ___ Female ___
 Address: _____ City: _____ Province: _____ Postal Code: _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Birth date (d/m/y) _____ Age _____ Marital Status _____ Number of Children _____
 Occupation/Employer _____ Alberta Health Care # _____
 Emergency contact (name, relation, phone number) _____
 How did you hear about our office? _____
 Medical doctor name: _____ Are you a student? Yes ___ No ___

Are your symptoms the result of a: Motor vehicle accident? Yes ___ No ___ Date of injury: _____
 Work-related injury? *Yes ___ No ___

**If Yes, Please Note: We do not currently accept worker's injury cases (Worker's Compensation Board) If you are seeking a WCB claim, please let us know and we will recommend a chiropractor who does.*

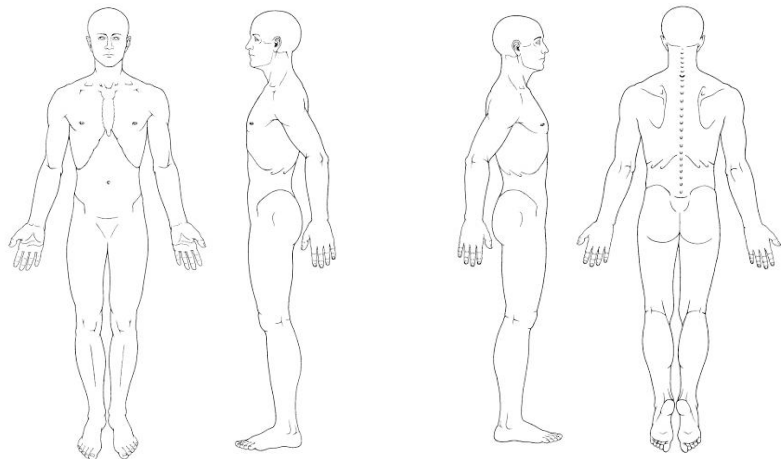
Have you had previous Chiropractic care? Yes ___ No ___ Doctor: _____ Date: _____
 What can we help you with today? _____
 Date this condition was first noticed: _____
 Did something specific cause this condition? _____
 Have you ever had similar problems? Yes ___ No ___
 Have you had X-rays, MRI or other tests for this condition? If yes, what tests and when? _____

Are your symptoms constant or do they come and go? _____
 What type of pain is it? Sharp Dull Ache Throbbing Burning Other _____
 Does it radiate anywhere? Yes ___ No ___ (If so, where?) _____
 How would you rate the severity of the pain on a scale of 0-10? (0=no pain,10= worst pain imaginable): _____

Since the problem started, is it... Improving About the same Getting worse
 Does anything make it feel better? _____
 Does anything make it feel worse? _____
 Does the condition interfere with: Work Sleep Walking Sitting Leisure
 Other (please describe) _____

Please label the area of complaint with the following letters:

- S = Sharp
- D = Dull
- Th = Throbbing
- M = Muscle tightness
- N = Numbness
- T = Tingling
- * = Other: _____



Please list ALL medications you are taking: (prescriptions, vitamins, herbal support, aspirin, etc.)

Have you seen other healthcare professionals for this condition? (please include name and date)

Physiotherapist: _____

Massage Therapist: _____

Acupuncturist: _____

Other: _____

Please mark any symptoms you have had, even if they do not seem related to your current problem. Often seemingly unrelated symptoms can manifest as other health concerns.

C = Current Problem

P = Problem in the Past

- | | | | | |
|---------------------------------------|---------------------------------------|--|--|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Hearing disturbances (loss, ringing, etc) | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Toe numbness | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Finger numbness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Slurred speech or other speech problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Problems urinating | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & needles | <input type="checkbox"/> Heart or blood diseases | <input type="checkbox"/> Whiplash injury |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Menstrual pain and/or irregularity | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hardening of arteries | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Problems sleeping |

Is there any other health condition you are dealing with? _____

Were you ever a smoker? From _____ To _____ How often? _____

Do you drink alcohol? No ___ Yes ___ (how often?) _____

Have you been in any accidents? No ___ Yes ___ (please explain) _____

Have you had any surgery? No ___ Yes ___ (please explain) _____

Women: Are you pregnant? If yes, how many weeks: _____

Do you wear any form of Orthotics? No ___ Yes ___ (How long) _____

Describe your current stress level (1 = none, 10 = extreme): Occupational _____ Personal _____

Approximately how many hours of sleep do you get each night? _____

What position do you sleep in most often? _____

Three Types of Care

Please initial beside the type of care you are most interested in. Keep in mind that you can change your mind at any time.

_____ **1. Relief Care** The goal of relief care is to reduce or eliminate a specific problem, usually pain. The length of time necessary to accomplish this will depend on your current state of health. This can be affected by your age, underlying spinal condition, length of time you've had the condition, and other lifestyle choices.

_____ **2. Corrective Care** In most cases, pain is the last thing to show up and the first thing to leave during treatment. The goal of corrective care is to help restore the body to normal function. This type of care continues *beyond the relief of symptoms* to focus on correcting the underlying cause of your problem.

_____ **3. Maintenance Care** In this phase of care, people have generally been through the first two phases of care and are now interested in maintaining their health. Maintenance care often involves periodic check-ups to help prevent old problems from returning or new ones from occurring.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature

Date