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____

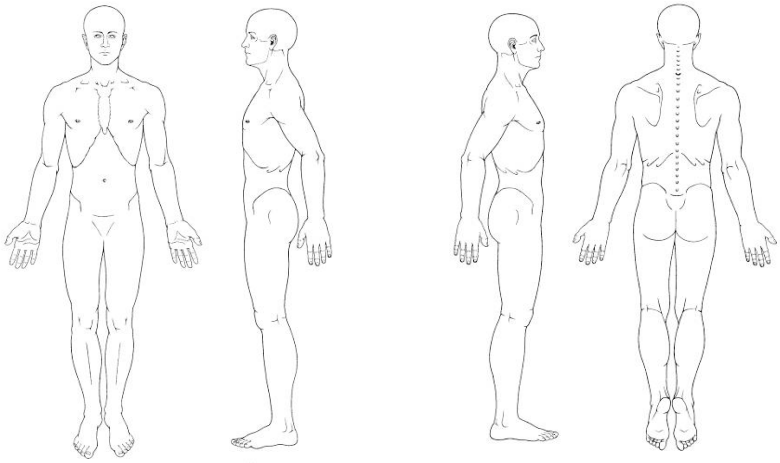
*****_If Yes, Please Note: We do not currently accept worker's injury cases (Worker's Compensation Board) If you are seeking a WCB claim, please let us know and we will recommend a chiropractor who does._

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.)

_____
_____
_____

{ Please Turn Page Over }

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**

__Back Pain	__Neck Pain	__Loss of balance	__Hearing disturbances (loss, ringing, etc)	__High blood pressure
__Fever	__Toe numbness	__Loss of taste	__Stomach problems	__Finger numbness
__Fatigue	__Depression	__Irritability	__Slurred speech or other speech problems	__Cancer
__Cold hands	__Cold feet	__Sore throats	__Problems urinating	__Sensitivity to light
__Constipation	__Headaches	__Pins & needles	__Heart or blood diseases	__Whiplash injury
__Heartburn	__Diabetes	__Diarrhea	__Menstrual pain and/or irregularity	__Stroke
__Ulcers	__Allergies	__Asthma	__Hardening of arteries	__Weakness
__Dizziness	__Stiff neck	__Ear infections	__Loss of consciousness	__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