WEST LETHBRIDGE FAMILY CHIROPRACTIC
NEW PATIENT FORM

Last Name: __________________First Name: _________________Gender_________Date:___________
Address: ____________________________City: __________ Province: ________Postal Code: ________
Home Phone___________________ Cell Phone_________________ Work Phone__________________
Birth date (***m/d/year***) __________________Age_____ Marital Status________ Number of Children_____
Email Address(optional)____(used for appointment reminders & important office updates)
Occupation/Employer____
Emergency contact (*name, relation, phone #*)____
Alberta Health Care #________________Insurance Co_________________ Policy #_________ID #_____
Medical Doctor's Name: _____________________________Are you a student? Yes______ No_________
How did you hear about our office? ____
Are you symptoms the result of a: Motor vehicle accident? Yes____ No____ Date of Injury:____________
Work - related injury? *Yes____ No____

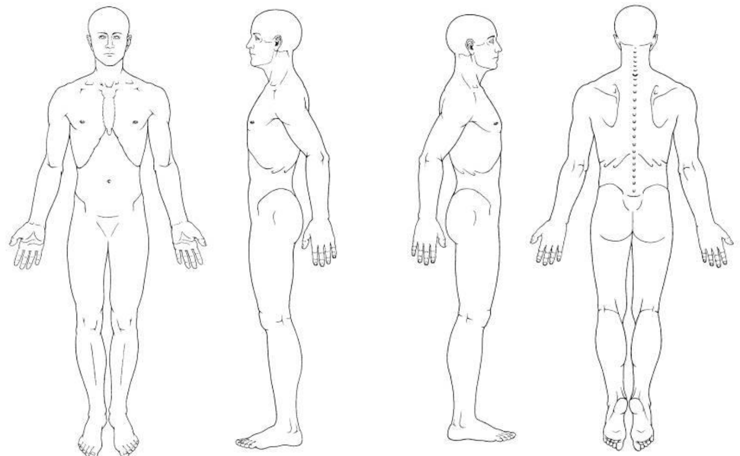
**If Yes, Please Note: We do not currently accept worker's injury cases (Worker's Compensation Board) If you are seeking a WCB claim, please let us know and we will recommend a chiropractor who does.*

Our office collects personal health information as per the Health Information Act (HIA) of Alberta. This information is used solely to provide the best care to you, our patient, and will not be released or disclosed to a third party without authorization from you.

Have you had previous Chiropractic care? Y___ N___ 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, when and what tests? ___________
____
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 □ 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 on the body with the following letters:

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



Please list **ALL** medications/supplements you are taking: (i.e. prescriptions, aspirin, vitamins, herbal support, 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	__Hemorrhoids	__Asthma	__Hardening of arteries	__Weakness
__Dizziness	__Stiff neck	__Ear infections	__Loss of consciousness	__Problems sleeping
__TMJ (Jaw Troubles)		__Blurred Vision	__Allergies (Please list)______________________________________	

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.

________________________________ ________________
Signature of Patient or Legal Guardian Date