

## WEST LETHBRIDGE FAMILY CHIROPRACTIC NEW PATIENT FORM

(Circle one)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M F 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 \_\_\_\_\_  
 Occupation/Employer \_\_\_\_\_  
 Emergency contact (name, relation, phone #) \_\_\_\_\_  
 Alberta Health Care # \_\_\_\_\_ Blue Cross/ASEBP or ARTA # \_\_\_\_\_ Group # \_\_\_\_\_  
 Medical Doctor's Name: \_\_\_\_\_ Are you a student? Yes \_\_\_\_\_ No \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_

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

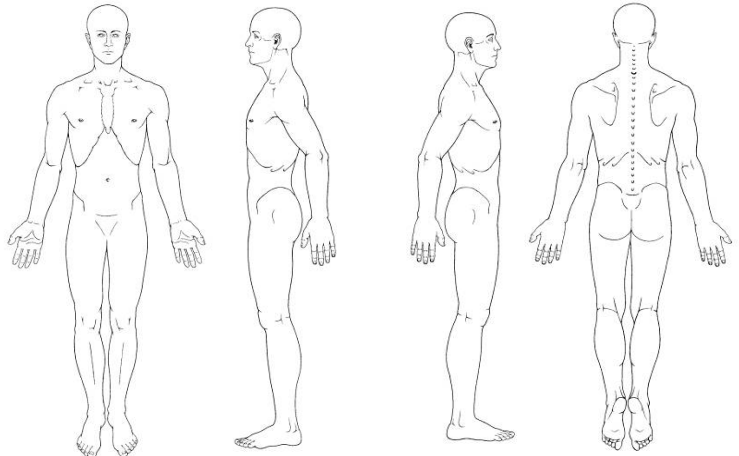
*\*If Yes, Please Note: We do not currently accept worker's injury cases (Worker's Compensation Board) If you are seeking a WCB claim, please let us know and we will recommend a chiropractor who does.*

Have you had previous Chiropractic care? 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.)

\_\_\_\_\_

\_\_\_\_\_

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"/> Hemorrhoids  | <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    |
| <input type="checkbox"/> TMJ (Jaw Troubles) |                                       | <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> 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.