BACK TO WELLNESS FAMILY CHIROPRACTIC

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Chiropractor

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CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us to determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name: _____ Birth Date: _____ Age: _____

Mailing Address: _____ City: _____

Postal Code: _____ Home Phone: _____ Bus. Phone: _____

Marital Status: M S W D Spouse's Name: _____ Do you have Children? _____

Employer: _____ Occupation: _____

Name of person who referred you to our office: _____

HEALTH INFORMATION

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What makes it feel better? _____

What aggravates your condition? _____

Is this condition getting progressively worse? _____ Have you had x-rays of your spine in the past year? _____

Have you had other doctors treat this condition/who? _____

Height: _____ feet _____ inches _____ Weight: _____ lbs. Shoe Size: _____ Shoe Width: _____
(narrow, regular, wide)

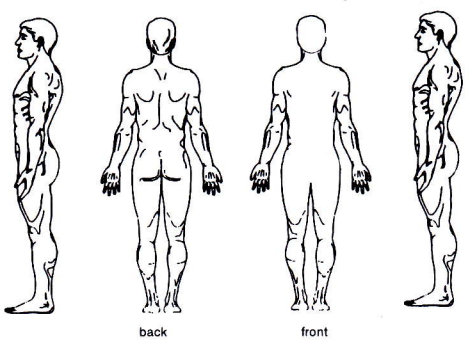
Activity Level: (circle one) Low Medium High

Have you ever suffered from: (circle Yes or No)

Dizziness	Yes	No	Heart Trouble	Yes	No
Backaches	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Headaches	Yes	No
Asthma	Yes	No	Neck Pain	Yes	No
Neuritis	Yes	No	Digestive Disorders	Yes	No
Sinus Trouble	Yes	No	Nervousness	Yes	No

Other: _____

Please circle areas of pain:



CONFIDENTIAL PATIENT CASE HISTORY

Name: _____

Other Complaints? _____

Have you had previous chiropractic care? _____ When?: _____

Name of Chiropractor: _____ Where?: _____

Why? _____

Family Doctor's Name: _____ Last Physical Exam: _____

List surgical operations and dates: _____

Do you take: Please check off all that apply

Tranquilizers_____ Birth Control Pills_____
Muscle Relaxers_____ Vitamins_____
Pain Killers_____ Pep Pills_____
Insulin_____ Nerve Pills_____

How do you sleep?

On your stomach_____ On your side_____ On your back _____
Age of your mattress:_____
Are you comfortable at night?_____
How many hours of sleep do you get?_____

Are you wearing: Yes or No

Heel lifts_____ Sole lifts_____ Arch Supports_____

Have you ever been in an automobile accident? _____

If yes, please indicate if it occurred within: the past year_____ past 5 years_____ over 5 years_____

What were your injuries? _____

What are your interests & hobbies? _____

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weaknesses. The information requested about your immediate family members will give us a better picture of your health.

Have you or a family member had a history of the following: (please check off the applicable answers)

Asthma_____ Cardiovascular Disease_____ Lumbago_____ M.S._____
Allergies_____ Learing Disability_____ Diabetes_____ H.I.V._____
Arthritis_____ Hyperactivity_____ Epilepsy_____ Cancer_____
Alcoholism_____ Stomach Ulcers_____ Bed Wetting_____ Depression_____
Schizophrenia_____ Other: _____

I understand that any insurance coverage besides O.H.I.P. is an arrangement between the insurance company and myself. I understand that Back to Wellness Family Chiropractic will prepare any necessary reports and forms to assist me in collection from the insurance company. Furthermore, I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays will be performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective terms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor.

I have read the above statements and consent to treatment.

_____ _____ _____

Print Name Signature Date