Power Health Chinook

Chiropractic, Acupuncture and Massage Therapy

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

❍ Single ❍ Married ❍ Widowed ❍ Separated ❍ Divorced Number of Children: _____

Date of Birth (MM/DD/YYYY) _____ Age: _____ Gender: ❍ Male ❍ Female

Alberta Health Care Number: _____

Phone Numbers: Home: _____

Business: _____

Cell: _____

Email Address: _____

Would you like email reminders for appointments? ❍ Yes ❍ No

Would you like to receive our Monthly Health Tips by email? ❍ Yes ❍ No

Spouse/ Partner: _____

In case of emergency, whom should we notify? _____

Relation to you: _____ Contact number: _____

Your Occupation: _____ Employer: _____

Have you had previous Chiropractic care/Physiotherapy/Acupuncture? ❍ Yes ❍ No

Reason: _____ Date: _____

REFERRAL INFORMATION

How were you referred to us?

❍ Personal Referral: _____ ❍ Internet

❍ Physiotherapist ❍ Location

❍ Massage Therapist ❍ Family Physician: _____

❍ Other: _____

If you weren't referred, how did you hear about us? _____

Purpose of today's appointment: _____

Are your symptoms due to a motor vehicle accident?

❍ Yes ❍ No

Are your symptoms due to work-related injuries that involve the Workers Compensation Board (WCB)?

❍ Yes ❍ No

Describe your symptoms and how they began:

_____

_____

When did your symptoms start? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

How are your symptoms changing? ❍ Getting better ❍ Staying the same ❍ Getting worse

How often do you feel your symptoms?

❍ Daily

____ x Week

____ x Month

When are they the worst?

❍ Morning

❍ Afternoon

❍ Evening

What best describes your pain?

❍ Sharp ❍ Dull ache

❍ Numb ❍ Shooting

❍ Burning ❍ Tingling

Using the following symbols, draw the location of your pain on the body outlines below.

LEGEND

Sensation	Symbol
Ache	^^^^
Burning	=====
Numbness	ooooo
Pins & Needles	.....
Stabbing	//////
Other	xxxxx

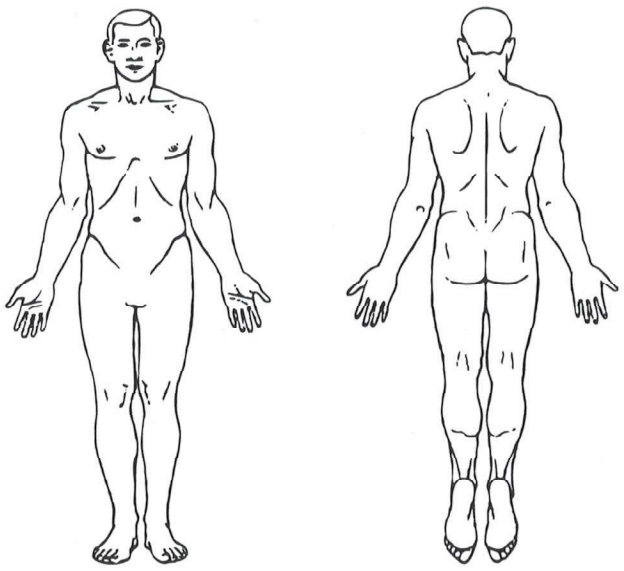
How often do you experience your symptoms?

a) Constantly (76%-100% of the day)

b) Frequently (51%-75% of the day)

c) Occasionally (26%-50% of the day)

d) Intermittently (0%-25% of the day)



What is the level of pain you feel right now:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

What is your pain level at its best:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

What is your pain level at its worst:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

If you have had any diagnostic imaging done recently please list the body area and facility it was done at:

_____

Please rate your level of overall stress:

Not stressed at all 0 1 2 3 4 5 6 7 8 9 10 Extremely stressed

Trauma History

This is important as old injuries can have an impact on what you are experiencing today.

Accidents: _____

Falls: _____

Surgeries/Operations: _____

Scars: _____

Hospitalizations: _____

Do you smoke? ❍ Yes ❍ No If yes, how many packs a day do you smoke? _____ packs/day

If no, have you smoked in the past? ❍ Yes ❍ No

How long ago did you quit? _____

Please indicate which of the following you have or have had:	Yes	No	Comments
Recent changes in bladder or bowel function			
Dizziness or vertigo			
Recent changes in weight or appetite			
Bruising or bleeding disorders			
Changes in vision (ie. blurred or double vision)			
Recent episodes of nausea or vomiting			
Stomach issues such as bloating or abdominal cramping (ie. IBS)			
High blood pressure			
Cardiac problems			
Transient Ischemic Attack (TIA) or Stroke			
Diabetes			
Thyroid problems			
Do you have a history of oral steroid use? (e.g. Prednisone)			
Cancer of any sort. If yes, what kind and when?			
Do you have a pacemaker?			

Please indicate if any of the following conditions have occurred within your family and to whom they apply.

Family History	Grandparent	Sibling	Mother	Father	Comments
Cardiac problems					
Transient Ischemic Attack (TIA) or Stroke					
High blood pressure					
Diabetes					
Thyroid issues					
Back pain					
Arthritis					
Cancer (If yes, please state what kind)					
Other:_____					