Sharbot Lake
Chiropractic & Wellness

CASE HISTORY

Name _____Age _____Date _____

Address _____City _____ Prov._____ Postal Code_____

Phone (Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W

Occupation Employer _____
Phone (Work)_____

Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __
Other _____

Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __
Other _____

HEALTH REPORT

Reason for seeking care:
_____

List any other doctors seen for this:
_____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? __ Yes __ No If yes, explain:
_____

List the names of any relatives that have or have had a similar problem:
_____

Have you or any relative received chiropractic treatment previously? __ Yes __ No
If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____

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Name_____ Date _____

Are you currently taking medication? __ Yes __ No list medications:

_____

List conditions you are taking medications for:

_____

List the approximate dates of any surgery or treated conditions:

_____

_____

FAMILY HISTORY

Health conditions, age of death and cause of death.

Father: _____

Mother: _____

Brother/s & Sister/s:

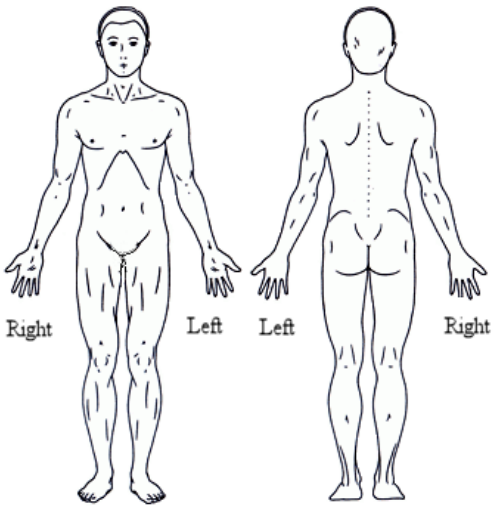
_____

Do you smoke Y/N ____ Alcohol Y/N __Daily __Weekly __Social Occasions

Caffeinated drinks per day ____

Do you take Vitamins/Supplements Y/N If yes, type and how often

_____



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

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Name_____ Date _____

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with: Work?_____Sleep?_____Routine?_____Other?_____

Is this condition progressively getting worse?

_____

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Date: _____ Patient Name: _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient
Signature_____Date_____