WOW chiropractic
put some wow into your life

Last Name:	First Name:	Gender: M / F
Address:	City, Province:	Postal Code:
Phone (Home) ( )	Phone (Work) ( )	Phone (Cell) ( )

Alberta Health Care #		Third Party Insurance #	
Emergency Contact Name:		Emergency Contact Phone ( )	
Date of Birth:	Age:	Height:	Weight:
Occupation:		Marital Status: Single Married Widowed Divorced	

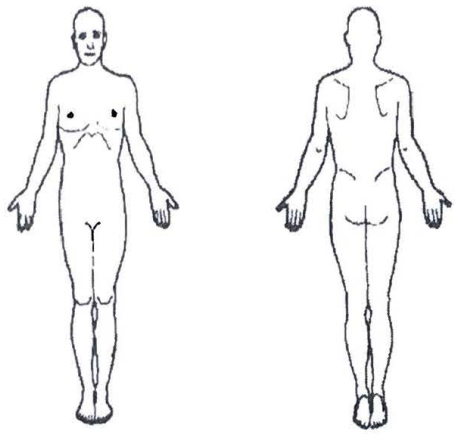
Email address: _____

Reason(s) for appointment: _____

When did your condition begin? _____

Please check all answers and fill in the blanks where appropriate.

Indicate the location of your pain by shading in the appropriate area(s):



How long have you had the condition?
Days___ Weeks___ Months ___ Years___

Did your complaint(s) come on: Suddenly?___ Gradual ___

Is this complaint(s) getting: Better?___ Same?___ Worse?___

Is the condition worse in the: AM?___ PM?___ No change?____

Is the problem: Constant?___ Intermittent?___ Worse with movement?___

Does the condition interferes with:
Sleep?___ Work?___ Family Life?___ Exercise?___

What aggravates your condition/pain?_____

What relieves your condition/pain?_____

What have you done for the complaint(s) so far?
Meds?____Massage?____Physio?____Acupuncture?____Exercise?

Do you experience any tingling or numbness in your:
Arms?____ Hands?____ Buttocks/hips?____ Legs?____ Feet? ____

Indicate the severity of the pain by circling a number:
| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain

ACHY >>>> **NUMBNESS** ==== **THROBBING** ~~~~
PINS & NEEDLES oooo **STABBING** ////

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. _____ Date: _____

Family doctor name: Dr. _____

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: _____

_____

_____

Have you had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No Which tests, when?_____

Is this a work related injury? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No On what date did the accident occur? _____

Can you perform daily home activities? ☐ Yes ☐ Yes, but only with help ☐ Not at all

Can you perform your daily work activities? ☐ All activities ☐ Only some activities ☐ Not at all

Describe your stress level ☐ None ☐ Mild ☐ Moderate ☐ High

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

What kinds of exercise do you do? _____

List all previous surgeries, illnesses, injuries (including MVA): _____

_____

_____

Family History: **Stroke** ☐ Yes ☐ No **Heart Attack** ☐ Yes ☐ No **Diabetes** ☐ Yes ☐ No **Cancer** ☐ Yes ☐ No

Systems Review:

Circle any conditions that are **presently** causing you a problem.

GENERAL SYMPTOMS

Fever
Sweats
Fainting
Sleep disturbance
Fatigue
Nervousness
Weight loss
Weight gain

NEUROLOGICAL

Visual disturbance
Dizziness
Fainting
Convulsions
Headache
Numbness
Neuralgia (nerve pain)
Poor coordination
Weakness

EYES, EARS, NOSE, THROAT

Eye pain
Double vision
Ringing in ears
Deafness
Nosebleeds
Trouble swallowing
Hoarseness
Sinus infection
Nasal drainage
Enlarged glands

RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Wheezing
Difficulty breathing
Asthma

CARDIOVASCULAR

Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Hardening of arteries
Swollen ankles
Poor circulation
Palpitations
Cold hand or feet
Varicose veins

MUSCLE & JOINT

Neck pain
Low back pain
Arm pain
Shoulder pain
Leg pain
Knee pain
Foot pain
Pain/numbness down arms or legs
Pain between shoulders swollen joints
Spinal curvature
Arthritis
Fractures

GENITOURINARY

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Prostate trouble
Uncontrollable urine flow

GASTROINTESTINAL

Poor appetite
Difficult digestion
Heartburn
Ulcers
Nausea
Vomiting
Constipation
Diarrhea
Blood in stool
Gallbladder/jaundice
Colitis

FOR WOMEN ONLY

Painful menstruation
Hot flashes
Irregular cycle
Cramps or back pain
Vaginal discharge
Nipple discharge
Lumps in breast
Menopausal symptoms
Birth control pills
Miscarriages
Complications with pregnancy
Pregnant? Y / N Week?
Other:

Date: _____ Patient signature: _____