Westside Family Chiropractic

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CONFIDENTIAL PATIENT INTRODUCTION

Name_____

Address_____City_____Postal Code_____

Date of Birth_____Age_____Gender_____Occupation_____

Telephone/Res_____Bus_____Cell_____

Email_____ Marital Status_____

Which one of our patients referred you:_____

Major Complaints_____

Other Complaints_____

How long have you suffered with this problem? _____ Is it getting worse? _____

How much older does this problem make you feel? _____

How does this problem interfere with the following areas of your life?

Family: _____

Work: _____

Hobbies: _____

Social Life: _____

Have you ever had previous Chiropractic care? _____When _____Who _____

Previous Diagnosis and Treatment_____

Medical Doctor_____Address_____

I allow this office to share my medical information with my family doctor. Initial_____ Date_____

FAMILY HEALTH INFORMATION: Many health problems are the result of hereditary spinal weaknesses. This information about your family members will give us a better picture of your total health. Please list any member of your family who has had any kind of health problem.

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

Do you have any children?_____

Do they have any health problems? _____

LIFESTYLE

What sports activities/exercises do you perform on a regular basis? _____

_____ How often?_____

NUTRITIONAL:

Meals Skipped	Coffee-Daily	Alcoholic Beverages	Do you Smoke?	Personal satisfaction with diet
Daily:	( ) 1-2	( ) 1-2 daily ( ) 1-2 Weekly	Tobacco Y / N	( ) Highly Satisfied
Weekly:	( ) 3-4	( ) 3-4 ( ) 3-4 Weekly	Vape Y / N	( ) Satisfied
	( ) more	( ) more	Cannabis Y / N	( ) Unsatisfied
			# per day? _____	( ) Highly Unsatisfied

PSYCHOSOCIAL: Have any of the following occurred recently?

( ) Depression	( ) Divorce	( ) Drug/Alcohol Increase	( ) Change in Job Status
( ) Death	( ) Anxiety	( ) Sleep Disturbances	( ) Family Problems
( ) Increased Work Stress	( ) Chronic Fatigue	( ) Economic Stress	( ) Other:

HEALTH HISTORY

List any Surgeries_____

List any Accidents/Falls _____

Are you on any Medications? (please list) _____

CHECK THE CONDITIONS FOR WHICH YOU HAVE BEEN TREATED:

( ) Alcoholism	( ) Attention Deficit	( ) Epilepsy	( ) Mumps
( ) Allergies	( ) Cancer	( ) Heart Disease	( ) Pneumonia
( ) Anemia	( ) Cold Sores	( ) High Blood Pressure	( ) Rheumatic Fever
( ) Appendicitis	( ) Diabetes	( ) Infertility	( ) Scarlet Fever
( ) Arthritis	( ) Diphtheria	( ) Measles	( ) Stroke
( ) Arteriosclerosis	( ) Eczema	( ) Migraines	( ) Thyroid
( ) Asthma	( ) Emphysema	( ) Multiple Sclerosis	( ) Ulcers

HAVE YOU EVER:	YES	NO
Been knocked unconscious	( )	( )
Used a cane, crutch or other support	( )	( )
Been treated for spine or nerve disorder	( )	( )
Had a fractured bone/broken bone	( )	( )
Been Hospitalized	( )	( )

DATE OF LAST:
Spinal Examination
Physical Examination
Blood Test
Chest X-Ray
Spinal X-Ray
Dental X-Ray
Urine Test

FOR WOMEN ONLY: When did your last period start? _____ Are you pregnant? Yes No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered are charged directly to me and I am personally responsible for payment to this clinic.

Signature_____ Date_____