PALMER CHIROPRACTIC & WELLNESS CENTRE

Date: _____ 765 Balm Beach Rd, Midland ON L4R 4K4 | Tel: 705.526.0006 Fax: 705.526.5558

Name: _____ Preferred name: _____

Address: _____

City: _____ Postal Code: _____

Phone #s: Home: _____ Cell: _____ Business: _____

Is it okay to contact you at work? no ○ yes ○

E-mail address: _____ Web site: _____

Birth Date: dd/mm/year: _____ Age: _____

Occupation: _____ Employer: _____

Marital status: single ○ married ○ separated ○ divorced ○ widowed ○

Spouse's name: _____ Phone #(s): _____

Children's names and ages: _____

Emergency Contact: Name_____ Relationship: _____

Contact phone #(s): _____

Favorite hobbies or interests: _____

WHAT BRINGS YOU HERE?

Have you ever had chiropractic care before? no ○ yes ○

If yes, please tell us the doctor's name: _____

Were you pleased with your care: no ○ yes ○

How did you find out about our office? _____

Is this appointment related to: work ○ sports ○ auto ○

personal injury ○ other ○

When did the incident occur? _____

Are you receiving care from other health professionals? no ○ yes ○

If yes, please name them and their specialty: _____

_____

Please list any drugs or medications you are taking: _____

_____

_____

Please list any vitamins/herbs/homeopathics/others you are taking: _____

_____

Are you pregnant: no ○ yes ○ If yes, what month? _____

CURRENT HEALTH

What are your most pressing health concerns? _____

_____

For how long? _____

Is it… getting worse ○ improving ○ intermittent ○ constant ○ can't say ○

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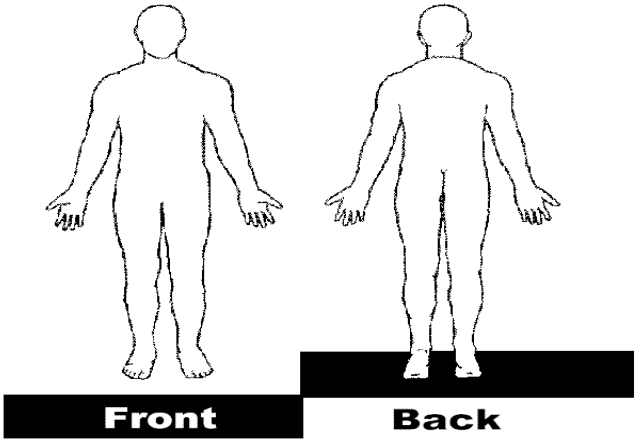

Where is the problem? Please use an X to indicate problem areas and lines below to explain.

Front: _____

_____

Back: _____

_____

Do you have	pain ○	numbness ○	tingling ○	aches ○	
Is your pain	sharp ○	dull ○	throbbing ○	constant ○	intermittent ○
Are yours symptoms	sitting ○	standing ○	walking ○		
Affected by	bending ○	lying down ○	weather ○		

Please explain _____

Do you feel cramps ○ burning ○ other ○ _____
swelling ○ stiffness ○

Do your symptoms interfere with work ○ sleep ○ other ○ _____

Please explain: _____

On a scale of 1-10 (1 least, 10 most), please rate:
The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

Do you have, or have you had, any of the following (please circle all that apply)

pneumonia	mumps	influenza	rheumatic fever	smallpox
pleurisy	polio	chickenpox	thyroid disease	diabetes
epilepsy	cancer	depression	whooping cough	anemia
eczema	measles	arthritis	heart disease	rashes

If you have ever been diagnosed with another disease or condition, please describe_____

_____

Do you use? coffee ○ tea ○ artificial sweeteners ○ sugar ○
alcohol ○ cigarettes ○ recreational drugs ○

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Have you ever suffered from (please circle all that apply)

abnormal blood pressure	dental problems	hand pain/tingling	neck pain
allergies	depression	headache	nervousness
ankle swelling	difficulty breathing	heart problems	numbness
arm back/tingling	difficulty hearing	heartburn	painful urination
black or bloody stools	discolored urine	hemorrhoids	paralysis
bladder trouble	dizziness	irritable bowel	poor appetite
blurred vision	ear pain	irregular heartbeat	prostate problem
breast pain/lump	excessive appetite	jaw pain	shoulder pain
chest pain	excessive thirst	leg pain/tingling	stroke
cold extremities	excessive urination	liver problems	stuffy nose
colitis	fainting	loss of sleep	tingling
confusion	fatigue	low back pain	vision problems
constipation	frequent nausea	lung problems	vomiting
cramps	gas/bloating after meals	migraines	weight loss

If applicable, date of last menstrual period _____

Past injuries can affect present health (please circle all that apply)

falls / accidents	head injuries	fights
sports injuries	broken bones	dislocation
spinal tap	surgery	traction
use (d) a cane or walker	extensive dental work	dental appliances
knocked unconscious		

If yes to any of the above, please describe _____

_____

_____

WHAT DO YOU KNOW ABOUT CHIROPRACTIC?

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? no ○ yes ○

If yes, do you use chiropractic for health maintenance/optimization ○
health problems ○ both ○

Are you seeking chiropractic for health maintenance/optimization ○
health problems ○ both ○

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you'd like us to know about you?

no ○ yes ○ If yes, please tell us.

_____

_____

Notes: _____

The above information is accurate to the best of my knowledge.

_____ _____

Signature Date

I, parent/guardian, give permission for minor's care.

_____ _____

Signature Date