





SYMPTOMS AND ILL HEALTH

Present reason for consulting our office: _____


If you are experiencing ill health, please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Use the symbols provided below.

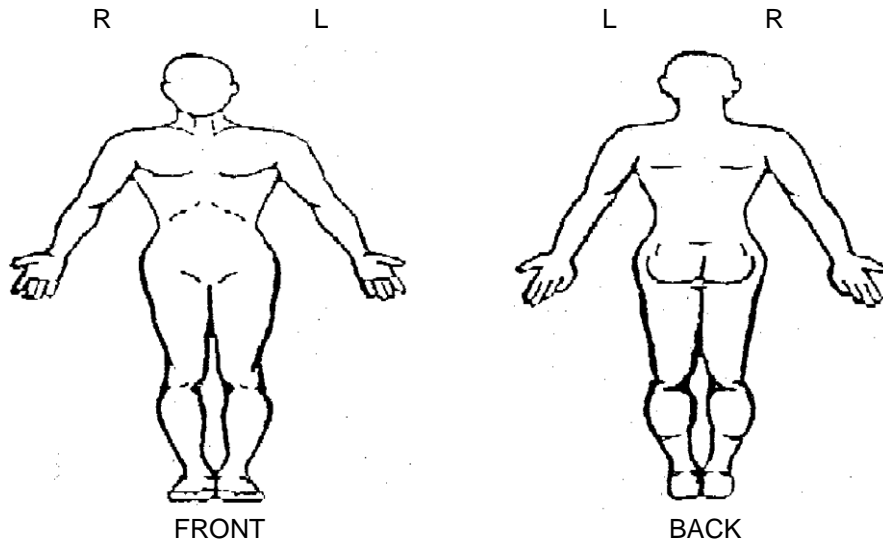
Symbols:

Stabbing & Sharp 

Dull & Aching 

Stiff and Tight 

Numbness 



How long have you been living with your condition? _____

How did your condition begin? _____

Is this condition related to: WORK: () YES () NO
 If "YES", have you notified your employer? () YES () NO

MOTOR VEHICLE ACCIDENT: () YES () NO When: _____

What makes it worse? _____

What makes it better? _____

Have you ever had similar problems before: () YES () NO

Have you had x-rays, MRIs, or other imaging done for your condition? () YES () NO. If yes, when and where: _____

Can you perform your daily home activities? () YES () YES with help () NOT AT ALL

Can you perform your daily work activities? () YES () YES with help () NOT AT ALL

What type of health care have you had in the past for your condition?

- () Medications
- () Injections
- () Physiotherapy
- () Massage Therapy
- () Chiropractic—reason for last visit
- () Other: _____



EVENTS AND HABITS

Have you had any major traumas in your life that would have built up over time? If so, please describe:

Have you ever had or do you currently have any of the following conditions: (Check all that apply)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Attack or Stroke | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Blood Clots in your legs | |
| <input type="checkbox"/> Cirrhosis or serious liver damage | |
| <input type="checkbox"/> Emphysema, chronic bronchitis, or chronic obstructive lung disease | |

Do you have a family history of any of the above conditions? If so, please describe: _____

Medications: Please list the names of the medications and supplements you take (prescription medications, vitamins, herbal supports, aspirin, etc): _____

Surgical History: If you have had any past surgeries, please indicate what operations you have had.

Do you have any allergies that we should be aware of (e.g., lotions)? _____

Please circle (O) any conditions or symptoms presently causing you problems:

GENERAL SYMPTOMS

- Fever
- Sweats
- Fainting
- Sleep disturbance
- Fatigue
- Nervousness
- Weight loss
- Weight gain

NEUROLOGICAL

- Visual disturbance
- Dizziness
- Fainting
- Convulsions
- Headache
- Numbness
- Nerve pain
- Poor coordination
- Weakness

MUSCLE & JOINTS

- 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

E.E.N.T.

- Eye pain
- Double vision
- ringing in the ears
- Deafness
- Nose bleeds
- Trouble swallowing
- Hoarseness
- Sinus infection
- Nasal drainage
- Enlarged glands

RESPIRATORY

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

GENITOURINARY

- Frequent urination
- Trouble urinating
- Painful urinating
- Blood in the urine
- Pus in urine
- Kidney infection
- Prostate trouble

CARDIOVASCULAR

- Rapid beating heart
- Slow beating heart
- High blood pressure

- Low blood pressure
- Pain over heart
- Harding of arteries
- Swollen ankles
- Poor circulation
- Palpitations
- Cold hands or feet
- Varicose veins

GASTROINTESTINAL

- Poor appetite
- Difficult digestion
- Heart burn
- Ulcers
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Blood in stool
- Gallbladder/Jaundice
- Colitis/Crohn's

FOR WOMEN ONLY

- Painful menstruation
- Hot flashes
- Irregular cycle
- Cramps or back pain
- Vaginal discharge
- Nipple discharge
- Lumps in breasts
- Menopausal symptoms
- Miscarriages
- Pregnant? Y / N Week: _____



LIFESTYLE

Does your present condition impact your lifestyle (e.g., relationship with family, friends, work, etc.; your ability to enjoy your social activities, etc.)? If so, please describe: _____

How does this impact your stress level? () None () Mild () Moderate () High

Do you exercise? () Daily () Occasionally () Not at all

Describe: _____

Do you have any NEGATIVE lifestyle habits that may impact your health and ability to heal (e.g., smoking, excessive alcohol intake, poor diet, etc.)? If so, please describe: _____

Thank you for completing the above information.
Please take a moment to review the information below

Payment: Our clinic operates on a fee for service model. Our practice members are responsible for the costs of the services provided by the Doctor, (which are in accordance with the Alberta College and Association of Chiropractors established fee schedule guidelines) and/or the services provided by any other professional provider at Family First Chiropractic and Wellness. Most extended health plans cover our services.

Direct Claims Submission Authorization: We can directly claim our services to some extended health providers. If applicable, and as the plan member/policy holder, this is to authorize us to directly submit the required information for the purposes of claims, services, and billing processing.

Social Media: Family First Chiropractic and Wellness does have social media accounts (e.g., Facebook, Twitter). As administrators of our accounts, we will not disclose any protected or confidential information of our members and patients as required by law. However, Family First Chiropractic and Wellness social media sites are public sites for those who join them, and anything posted by fans or friends may be publicly viewed.

If you have any questions on this information, please let us know.

Print Name: _____
(practice member, or parent/guardian if under 18)

Date: _____

Signature: _____