ALLSPORT HEALTH & PERFORMANCE

Date: _____

PATIENT INFORMATION

Paitent's Last Name: _____First Name: _____
Home Address: _____City: _____ Postal Code: _____
Date of Birth: D____/M____/ Y____Age:_____Gender: ☐ Male ☐ Female
Occupation: _____Employer:_____
Business Phone: _____
Marital Status: _____Name of Spouse: _____
No. of Children? _____
Who is legally responsible for this account? _____
By Whom were you referred?_____

CONTACT INFORMATION

Home Phone: _____
Cell Phone: _____
Email: _____

Emergency Contact

Name: _____
Phone Number: _____

PROVINCIAL HEALTH CARE INSURANCE PLAN

Alberta Healthcare #: _____
Other Health Insurance:
_____
_____

CHIROPRACTIC HEALTH INFORMATION

(Please circle your answer to each question. If yes, please explain)

Have you had previous chiropractic care? ☐ no ☐ yes Doctor: _____
What were you treated for? _____
How long has it been since you felt good? _____
Please list any surgical operations and years performed: _____
_____
Name of Medical Doctor: _____
Are you currently Taking: ☐ birth control ☐heart medication ☐insulin ☐ muscle relaxants
☐ Nerve Pills ☐pain pills ☐tranquilizers ☐vitamins _____
Age of Mattress: _____ How do you sleep: ☐ side ☐ back ☐ stomach ☐ combination
Have you ever been in an auto accident? ☐ yes ☐ no Describe: _____
Have you had a personal injury or accident? (Describe): _____
Interests/Hobbies? _____

FAMILY MEDICAL HEALTH INFORMATION

(FOR A FAMILY MEMBER MARK X, FOR YOURSELF PLEASE CIRCLE)

Do you or a family member have any of the following?

☐AIDS	☐Bed Wetting	☐Epilepsy	☐Schizophrenia
☐Alcoholism	☐Cancer	☐Hyperactivity	☐Stomach Ulcers
☐Allergies	☐ Cardiovascular disease	☐Learning Disability	☐Other
☐Arthritis	☐Depression	☐Lumbago	
☐Asthma	☐Diabetes	☐Multiple Sclerosis	

CURRENT PATIENT CONDITION

What is your major complaint at present time? _____

_____

When and how did your symptoms begin? _____

Have you had this condition before? If yes, when? _____

Is your condition getting progressively: ☐worse ☐better ☐staying the same

What makes it better? _____ What makes it worse? _____

Are your symptoms worse in the: ☐morning ☐daytime ☐evening ☐ constant

How does it feel? ☐ Burning ☐Sharp ☐Stiff ☐Ache ☐Numbness ☐Shooting ☐Tingling Other?_____

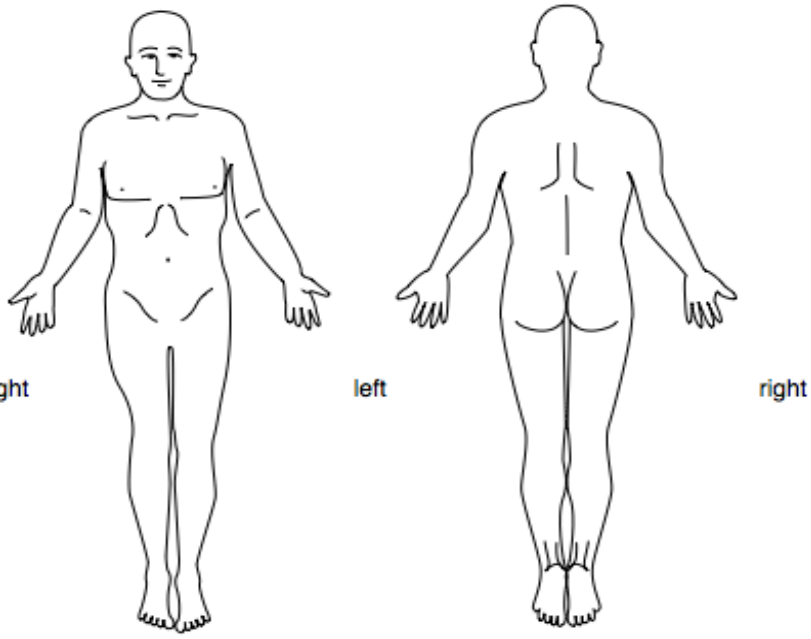
Is this condition interfering with your ☐ work ☐ sleep ☐ daily routine ☐other_____

How long have you had this condition? _____

Is the condition a result of a motor vehicle accident or workers compensation injury? _____

On the picture below, use the indicated marks to show areas where you have experienced the following symptoms:

PAIN: XXXX **NUMBNESS: ////** **TINGLING: 0000**



Additional Coments:

_____

_____

_____

_____

_____

For the dominant area of pain, how would you judge that pain on a scale of zero-to-ten (where zero is no pain and 10 is the worst pain imaginable). Place an "x" on the corresponding value on these scales:

ON THE AVERAGE: _____

0 **10**

AT IT'S WORST: _____