

NOVA SPINAL CARE

Personal History

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Birthdate: _____ Age: ____ Sex: M F
Business/Employer: _____ Business Phone: _____
Type of Work: _____ Cell # : _____
Circle One: Married Single Widowed Divorced Separated Other Number of Children: _____
Emergency Contact: _____ Phone Number: _____ Relationship: _____
Who may we thank for referring you to this office? _____
Email Address: _____ Do you approve email contact? ____ Initials

Current Health Condition

Current Complaint(s): _____

Other doctors seen for this condition? Yes No Who? _____

Type of Treatment: _____ Results: _____

When did this condition begin? _____ Has the condition occurred before? Yes No

Is the condition: Job-related Auto-related Home Injury Fall Other: _____

PLEASE NOTE THAT THIS OFFICE DOES NOT HANDLE WCB CLAIMS Initial: _____

What aggravates your condition? Sitting Standing Bending Lifting Walking
 Lying Down Cold Dampness Other: _____

What relieves your condition? Bed Rest Ice Heat Massage Medication
 Other: _____

Is it getting: Worse Constant Comes/Goes Better

Character of Pain: Sharp Dull Ache Pins & Needles Numb Burning
 Constant Intermittent

Please describe how it feels when this problem is at its worst: _____

Place an X on the grade to indicate the severity of your pain:
Slight 1 2 3 4 5 6 7 8 9 10 Extreme

How does this problem interfere with:
Your ability to work? _____
Your ability to enjoy your family or your social time? _____
Your ability to enjoy your hobbies or sports? _____

At its worst, how old does this problem make you feel? _____

If you don't get the problem corrected, do you think it will get worse over the next 5 years? Yes No

Drugs you take now: Nerve Pills Painkillers/Muscle Relaxers Blood Pressure Medicine
 Insulin Other: _____

Do you suffer from any other condition than the one you are now consulting us for? _____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____

Have you had X-rays taken in the last six months? Yes No If yes, where? _____

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Past Health History

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other: _____

Previous: Childhood Traumas _____ Sports Injuries _____
Motor Vehicle Accidents _____ Work Injuries _____

Details of accidents: _____

Hospitalization (other than above): _____

Previous Chiropractic Care: None Doctor's Name: _____

Approximate Date of Last Visit: _____

Family Health History

Name of Family Physician: _____

Please indicate any health issues that are present in your family:

Parents: _____

Siblings: _____

Have your children ever had a spinal check-up? No Yes If yes, where and when? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have had in the past six months:

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion / Depression
- Fainting
- Convulsions
- Cold / Tingling Extremities
- Stress

Musculo-Skeletal

- Low Back Pain
- Gas/Bloating After Meals
- Pain Between Shoulders
- Heartburn
- Neck Pain
- Black/Bloody Stool
- Arm Pain
- Colitis
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

General

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

Cardiovascular

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

Ears/eyes/nose/throat

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

Gastro-Intestinal

- Poor / Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

Male / Female

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain / Infections
- Breast Pain / Lumps
- Prostate / Sexual Dysfunction

Genito-Urinary

- Bladder Trouble
- Painful / Excessive Urination
- Discolored Urine

NOVA SPINAL CARE

Females Only

When was your last period?

Are you pregnant?

- Yes No Not Sure

Intake

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Satisfaction with Diet

- Highly Satisfied
- Satisfied
- Dissatisfied
- Highly Dissatisfied
- Would like more information

Do you have a regular exercise program?

- Yes
 No

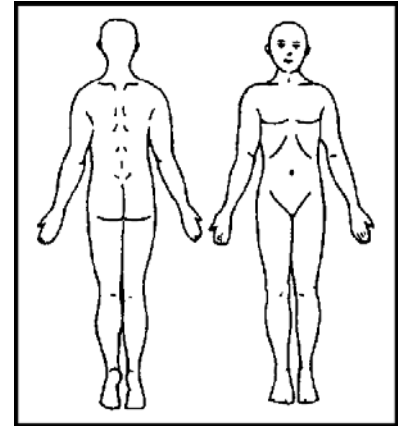
Lifestyle Stress Levels

- High
- Moderate
- Very Little

Check any of the following diseases you have had:

- Pneumonia
- Mumps
- Influenza
- Rheumatic Fever
- Small Pox
- Pleurisy
- Polio
- Chicken Pox
- Arthritis
- Tuberculosis
- Diabetes
- Epilepsy
- Whooping Cough
- Cancer
- Mental Disorder

- Anemia
- Heart Disease
- Lumbago
- Measles
- Thyroid
- Eczema



Please outline on the diagram the area of your discomfort and any radiation of pain.

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Your doctor will weigh your needs and desires when recommending your schedule of care. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care which best describes your current health goals:

- Preventative Care – Life Enhancement and Wellness Care
- Corrective Care – Removing Cause and Remodeling Soft Tissue
- Relief Care – Band-Aid Care Only
- Check here if you want the doctor to select the type of care appropriate for your condition.

To the best of my knowledge all of the above information on my health history is accurate and true.

Patient Signature

Date