doctor FOR moms | perinatal & pediatric natural health center

Patient Information

Date: _____ **Alberta Health Care Number**: _____

First Name: _____ Surname: _____ Middle Initial: _____

Date of Birth (M/D/Y):_____ Age: _____ Sex: M F

Address: _____

City: _____ Province: _____ Postal Code: _____

Occupation:_____ Marital Status:_____ Children:_____

CONTACT INFORMATION

	Number	Extension
Home:	_____	
Phone (bus):	_____	_____
Phone (cell):	_____	

Email Address: _____

*Please note that we are asking for your email address as a way to email you receipts, appointment reminders, or if we need to reach you for a specific/urgent reason. If you would like to be added to our newsletter mailing list please check here _____

Emergency Contact: _____ Contact Number:_____

REFERRAL INFORMATION

□ Personal Referral: _____ □ Internet: _____

□ Doctor Referral: _____ □ Massage Therapist: _____

□ Physiotherapist: _____ □ Midwife / Doula: _____

□ Other: _____

YOUR HEALTH CARE TEAM

Family Doctor: _____ Massage Therapist: _____

Naturopath: _____ OB/GYN: _____

Midwife/Doula: _____ Other Care Providers: _____

INSURANCE

Do you have Extended Health Coverage? □ Yes □ No

Insurance Company: _____

Motor Vehicle Accident (if applicable)

Are you seeking treatment for a Motor Vehicle Accident? □ Yes □ No

Date of Motor Vehicle Accident: _____

Have you seen another practitioner in regards to this accident? □ Yes □ No

Type of practitioner: □ Physiotherapist □ Medical Doctor □ Chiropractor

Name of Practitioner: _____ Date of Assessment: _____

Insurance Company: _____ Phone Number: _____

Name of Claim Worker: _____ Claim #: _____

CURRENT HEALTH CONDITION

Purpose of this Appointment: _____

Major Complaint: _____

Explain How Complaint Occurred: _____

When did this condition begin?: _____

Condition has persisted for: □ Days □ Weeks □ Months □ Years

Condition developed from: □ Auto Accident □ Work Injury □ Other Injury _____

Symptoms □ Came on suddenly □ Come & Go

What activities make this condition better? _____
What activities make this condition worse? _____

Symptoms are BETTER in: □ AM □ Midday □ PM

Symptoms are WORSE in: □ AM □ Midday □ PM □ Do not change with time of day

Have you ever had this condition before? □ No □ Yes, when _____

Other doctors seen for this condition: _____
Describe other complaints involving:

Neck/Head: _____

Mid-back/Shoulders/Arms: _____

Low-back/Hips/Legs: _____

Medications/supplements/vitamins you are taking:_____

For what conditions: _____

Women: Are you pregnant? □ Yes □ No How many weeks? _____Due Date:_____

INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

U – Unable P – Painful D – Difficult L – Limited N – Normal

_____Coughing or Sneezing	____Lying on side w/ Knees bent	_____Gripping
_____Getting in or out of car	_____Bending over forward	_____Pushing
_____Turning over in bed	_____Climbing	_____Pulling
_____Walking short distances	_____Kneeling	_____Reaching
_____Standing more than 1 hour	_____Balancing	_____Sexual Activity
_____Sitting at table	_____Dressing self	_____Holding child
_____Lying on back	_____Sleeping	_____Carrying car seat
_____Lying flat on stomach	_____Stooping	

PAST HEALTH HISTORY

CHECK ANY DISEASE / ILLNESS YOU HAVE HAD:

□ Rheumatic Fever □ Measles □ Pneumonia □ Fibromyalgia
□ Diabetes □ Small Pox □ Mumps □ Chrohns
□ Heart Disease □ Arthritis □ Chicken Pox □ Colitis
□ A.I.D.S. □ Influenza □ Cancer _____

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE and UNDERLINE THOSE YOU HAVE HAD IN THE PAST:

MUSCULO-SKELETAL
□ Low back pain
□ Pain between shoulders
□ Neck pain
□ Arm pain
□ Joint pain/Stiffness
□ Walking problems
□ difficult chewing/Clicking jaw
□ General stiffness

CARDIO-VASCULAR
□ Blood pressure problems
□ Heart problems
□ Lung problems/Congestion
□ Stroke
□ Chest pains

RESPIRATORY
□ Asthma
□ Difficulty Breathing

MALE/FEMALE
□ Menstrual Irregularity
□ Menstrual cramping
□Vaginal pain/Infections
□ Breast pain/Lumps
□Miscarriage
□ Difficulty Conceiving
□ Endometriosis/ovarian cysts

NERVOUS SYSTEM
□ Nervousness
□ Numbness_____
□ Dizziness
□ Forgetfulness
□ Confusion/Depression
□ Fainting
□ Convulsions
□ Cold/Tingling extremities
□ Stress

DIGESTIVE TRACT
□ Nausea
□ Heartburn
□ Gas/Bloating after meals
□ Constipation
□ Diarrhea
□ Bowel infections
□ Weight issues

EYE/EAR/NOSE/THROAT
□ Vision problems
□ Sore throat
□ Stuffed nose and sinuses
□ Hearing difficulty
□ Ear aches
□ Ear infections

GENERAL
□ Fatigue
□ Loss of sleep
□ Headaches
□ Fever
□ Poor appetite
□ Allergies _____

GENITO-URINARY
□ Bladder issues
□ Painful Urination
□ Excessive urination
□ Yeast infections

EXERCISE (check one)
□ none □ moderate □ daily
What? _____
_____
_____

FAMILY HISTORY (for example, Cancer/ Diabetes/Heart Problems/Back or Neck Pain)
Father: _____
Mother: _____
Brothers: _____
Sisters: _____

HABITS
□ Caffeine: cups/day: _____
□ Smoking: packs/day: _____
□ Drinking: alcohol/wk: _____
□ Fast Food: meals/wk: _____
□ Junk Food: items/wk: _____
□ Sleep: hours/night: _____
□ Stress: low moderate high

DIET
□ Poor
□ Average
□ Healthy (low fat, balanced meals)
□ Organic
□ Vegetarian
□ Vegan

Have you had previous Chiropractic Care? Yes No Dr._____

List all accident or falls: _____

Surgeries/ Operations: _____

Hospitalizations: _____

Date of last spinal X-rays: _____ Location?: _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (Preventative Care). These are the three types of care. As your doctor will weigh your needs and desires when recommending your schedule of care, please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Relief Care □ Corrective Care □ Preventative Care

□ Check here if you want the doctor to select type of care appropriate for your condition

I confirm that the information I have provided in regards to my current condition and past health history is true and complete to the best of my knowledge.

Signature: _____ Date: _____