Carling Family Chiropractic and Sports Injury Clinic

CARLING FAMILY CHIROPRACTIC
Sports Injury Clinic
2565 Carling Ave.
Ottawa, ON K2B 7H6

Confidential Patient History

Name _____ **Date** _____

Address _____ **City** _____ **Postal Code** _____

Phone # _____ **Cell #** _____ **Work #** _____

Date of Birth (d/m/y) _____ **Marital Status** _____ **Ages of children** _____

E-mail _____ **Occupation** _____ **Employer** _____

Medical Doctor _____ **Specialist Doctor** _____ **Specialty** _____

History (check A or B)

○ A) **I have NO specific complaint.** I want a chiropractic assessment to check for: spinal health/posture/joint dysfunctions et

○ B) **My specific health complaints are:** _____

When did you become aware of your primary or most significant health concerns? _____

The condition was caused by: _____ ☐ No Cause

Describe the symptoms - check all that apply:

☐ Burning ☐ Numbness ☐ Pins & Needles ☐ Weakness ☐ Pinching ☐ Sharp ☐ Dull

☐ Stiffness ☐ Like a Bruise ☐ Other - please describe _____

Is this the first occurrence of this issue? ☐ Yes ☐ No When was the last time? _____

Was the onset: ☐ Sudden ☐ Gradual ☐ Progressive

Is the problem: ☐ Getting worse ☐ Getting better ☐ Staying the same

Are the symptoms: ☐ Constant ☐ Comes and goes Worse on which movements _____

When is the discomfort more intense: ☐ Morning ☐ Daytime ☐ Evening ☐ Night

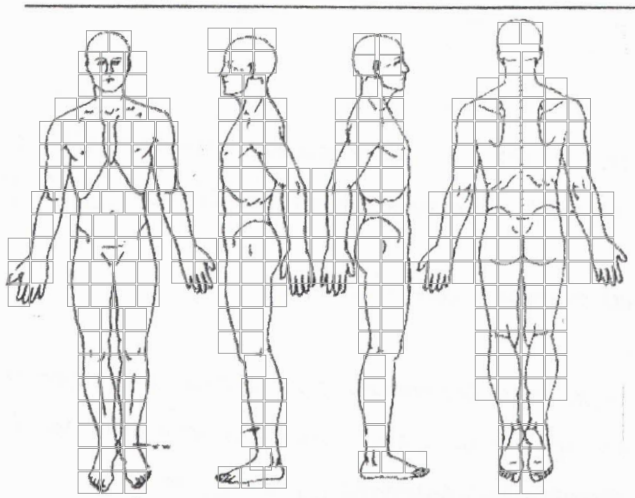
It wakes you? ☐ Yes ☐ No **Medication helps?** ☐ Yes ☐ No **Which medication?** _____

Did you take pain medication today? ☐ Yes ☐ No **Which medication?** _____

Which medication do you regularly take? _____

What aggravates your pain:

- ☐ To sit
- ☐ To get up after sitting
- ☐ To cough/sneeze
- ☐ Going to the toilet
- ☐ Stress
- ☐ To lean forward
- ☐ Lying down
- ☐ Activity
- ☐ Other (specify below)



Mark areas of sypmtoms on the body above

What relieves your pain:

- ☐ Ice
- ☐ Heat
- ☐ Stretching
- ☐ Changing position
- ☐ Medication
- ☐ Rest
- ☐ Lying down
- ☐ Activity
- ☐ Other (specify below)

Wellness Status

Have you had any significant...

Accidents? ☐ Yes ☐ No Year _____ Describe: _____

Falls? ☐ Yes ☐ No Year _____ Describe: _____

Sports Injuries? ☐ Yes ☐ No Year _____ Describe: _____

Motor Vehicle Accidents? ☐ Yes ☐ No Year _____ Describe: _____

Other Traumas? ☐ Yes ☐ No Year _____ Describe: _____

On a scale of 1 to 10 (1 being mild and 10 being extreme), please rate the following:

Rate the amount of stress in your life: _____ Rate the amount of stress at work: _____ Rate your wellness: _____

Do you suffer from any of the following problems? If yes, which year (e.g. P=Present problem, 98=1998 problem)

☐ Cancer	_____	☐ Allergies	_____	☐ Anxiety	_____	☐ Digestion	_____
☐ Intestine	_____	☐ Thyroid	_____	☐ Stroke	_____	☐ Diabetes	_____
☐ Dizziness	_____	☐ Prostate	_____	☐ Knee Pain	_____	☐ Lung	_____
☐ High BP	_____	☐ Concussion	_____	☐ Arthritis	_____	☐ Foot Pain	_____
☐ Sinusitis	_____	☐ Kidney/Liver	_____	☐ Headaches	_____	☐ Circulation	_____
☐ Constipation	_____	☐ Osteoporosis	_____	☐ Epilepsy	_____	☐ Heart Condition	_____

Have you ever had surgery? ☐ Yes ☐ No Year _____ Describe: _____

Have you ever been hospitalized? ☐ Yes ☐ No Year _____ Describe: _____

List any diagnosed health conditions that your blood relatives have had (e.g. father - stroke, sister - diabetes, etc.)

Do you wear orthotics? ☐ **Heel lifts?** ☐ **Pacemaker?** ☐

Any recent change in weight? ☐ Yes ☐ No ☐ Increase - how much _____ ☐ Decrease - how much _____

How would you rate your posture? ☐ Good ☐ Bad **Posture at your desk?** ☐ Good ☐ Bad

Frequency of exercise? ☐ Never ☐ 1-2 times a week ☐ 3 or more times a week ☐ Daily

Rate your diet: ☐ Excellent ☐ Good ☐ Poor

Do you take supplements? If so, please list them here.

Do you currently smoke? ☐ Yes ☐ No **Were you ever a smoker?** ☐ Yes ☐ No

Have you had X-rays taken during the last two years (other than dental)? ☐ Yes ☐ No **If yes, for what?** _____

Types of Care - Please check the type of care you desire:

☐ **Temporary relief only.**

☐ **Lasting correction.** Reconstructive care; eliminates cause of pain and greatly reduces probability of recurrence.

☐ **Wellness Care.** Preventative spinal maintenance ensuring optimal spinal health.

Have you previously received chiropractic treatment? ☐ Yes ☐ No **Last treated when?** _____

Treated by Dr. _____ **For similar/same condition?** ☐ Yes ☐ No

For which other condition? _____

Modes of treatment: **Results?** ☐ Excellent ☐ Good ☐ Poor