Kingston West Family Chiropractic — dedicated to excellence in natural family health

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CASE HISTORY

Name: ______________________________ Date: ______________

Address: ______________________________ Apt #: ______________

City: ________________ Province:____________ Postal Code:______________

Home Phone: ______________ Work Phone: ______________ Cell: ______________

E-Mail Address: ____

Date of Birth (D/M/Y) ________________ Age:________

Workplace: ____________________ Occupation: ____________________

Claim Will Be Made Against:

1. Recent motor vehicle accident ☐ Yes ☐ No (if yes, please let us know at reception)

2. Work related injury / accident ☐ Yes ☐ No (if yes, please let us know at reception)

HEALTH GOALS

IT IS IMPORTANT to us that we know what your health goals are. Please check off the statement that most closely reflects your health goals.

- ☐ **SYMPTOM RELIEF:**
- ☐ **CORRECTION OF THE PROBLEM:**
- ☐ **OPTIMIZING HEALTH:**

Chiropractic Care:

Have you had previous chiropractic care? ☐ Yes or ☐ No Where? ____________________

How long ago? __________ Why? ______________________________

Were you satisfied with the results? ☐ Yes or ☐ No Explain: ____________________

Medical Doctor:

Name: ______________________________ Phone: ______________

Address: ______________________________ Date of Last Physical Exam: ______________

How did you learn about our office?

Patient (Name): ____________________ Newspaper __________ Internet __________

Other health care provider (Name & Address): ______________________________

Other: ____

PERSONAL HEALTH HISTORY

What is your reason for attending our office today? ____

____

Are you currently or do you regularly suffer from the following symptoms:

☐Heel pain	☐Ankle sprains/trauma	☐Arthritis: foot/ankle/knees/hips/back
☐Plantar fasciitis	☐Knee pain/trauma	☐Headaches
☐Metatarsalgia	☐Hip pain	☐Numbness in toes
☐Heel spurs	☐Back Pain	☐Circulatory disorders
☐Achilles tendonitis	☐Neck Pain	☐Pins and needles in toes
☐ Bunions	☐Diabetes	☐Claw toes
☐Forefoot pain	☐Hammer toes	☐Corns
☐ Calluses	☐Flat feet	☐High arches
☐Shin splints	☐Patellofemoral syndrome	☐Iliotibial band syndrome

Drugs you now take: ☐ Anti-inflammatory ☐ Pain Killers ☐ Muscle Relaxants

☐ Blood Pressure ☐ Tranquilizers ☐ Insulin ☐ Birth Control Pills

☐ Other: ____

List all surgical operations and years: ____

Have you had any spinal x-rays taken in the last 2 years? ☐ Yes ☐ No

Where were they taken? ______________________________________

Your height: ________________________ Your weight:____________________________

Approximate shoe size (most commonly worn) ____________________________________

Do you currently wear: ☐ heel lifts ☐ orthotics ☐arch supports
If yes, to orthotics, how old are the orthotics? _______________ How many pairs do you have?
_________________ Where were they made? _______________________________

If you are not currently wearing orthotics, have you worn orthotics in the past? ☐Y ☐N

Please select what type of footwear that you wear approximately 80% of the time or greater.

☐Casual shoes	☐ Loafers	☐ Running shoes	☐ Walking shoes
☐Work boots	☐ Dress shoes	☐ Heels	☐ Sandals

LIFESTYLE HISTORY

YES	NO	
☐	☐	Are you a non-smoker?
☐	☐	Do you drink 8 glasses of water per day?
☐	☐	Do you drink fewer than 2 caffeinated beverages per day?

☐ ☐ Do you exercise regularly? ☐ Up to 3 hours/wk ☐ 3-6 hrs/wk ☐ over 6 hrs/wk

☐ ☐ Do you feel you have a healthy diet? (low fat, high fiber, raw foods)

☐ ☐ Do you drink one or less alcoholic beverage per day?

☐ ☐ Do you sleep well (6-9 hours uninterrupted)?

Age of mattress: ________________ What is your sleeping posture? ☐ Side ☐ Stomach ☐ Back

Are you under stress at: ☐ Work ☐ Home or ☐ School

Do you take any vitamins, herbs or other supplements? ☐ Yes ☐ No

Please list: ____

What is your job description? ____

What is your work schedule? ____

What are your hobbies? ____