Kingston West Family Chiropractic
dedicated to excellence in natural family health
Dr. Adrina Patterson D.C.

743 Cataraqui Woods Drive, Unit 1
Kingston, ON K7P 2R1
Phone: (613) 389-5331 Fax: (613) 389-7246
E-mail: info@kwfc.ca
www.kwfc.ca

CASE HISTORY

Name: _____ Date: _____

Address: _____ Apt/ Unit/ Suite #: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

E-Mail Address: _____

Date of Birth (D/M/Y) _____ Age: _____ ☐ Male ☐ Female ☐ Non-binary

Workplace: _____ Occupation: _____

Claim Will Be Made Against:

1. Recent motor vehicle accident ☐ Yes ☐ No (if yes, please let us know in advance or at reception)
2. Work related injury / accident ☐ Yes ☐ No (if yes please let us know in advance or 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/Acupuncture:

Have you had previous chiropractic/acupuncture? ☐ 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): _____ Facebook _____ Internet _____

Other health care provider (Name & Address):

Other: _____

PERSONAL HEALTH HISTORY

Name: _____ DOB: (D/M/Y) _____

What is the 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

Medications 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? _____

Family Health History

Please check off any conditions listed below that your immediate family members (Parents/Siblings/ Grandparents) have or have had and note their relationship (e.g. Mother, Father Brother) in the space provided

Condition	**Check if Applicable**	**Relation**
Chronic Back or Neck Pain	☐	
Scoliosis/ Spinal Deformity	☐	
Disc Problems (herniated/ bulging)	☐	
Osteoarthritis	☐	
Rheumatoid Arthritis	☐	
Stroke/ High Blood Pressure	☐	
Diabetes	☐	
Cancer	☐	
Other Major Health Condition (specify)	☐	

Name: _____ DOB: (D/M/Y) _____

Your height: _____ Your weight:_____

Approximate shoe size (most commonly worn) _____ ☐ M or W ☐

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? _____

Please note we have a 24-hour cancellation policy.

We value your time and we appreciate when you value ours as well as the time of other members of our practice. Appointments cancelled with less than 24 hours of notice will be charged the fee equivalent to the missed or cancelled appointment. We do realize that life happens sometimes and for extenuating circumstance, such as illness, and medical emergencies, we will make an exception.

Please initial to indicate that you have read and understand this policy. _____