Brix Family Chiropractic Centre

First Name:_____ Last Name:_____

Address: _____ Sex: M / F Age: _____
City: _____ Prov.: ____ Postal code: _____ Birthday(dd/mm/yy):_____
Home Phone: _____ Cell Phone:_____ Work Phone: _____
How did you hear about the office? _____
Employer: _____ Status (circle): married single
Number of Children and their ages: _____
Email Address: _____

Patient History
Please check any of the following that may apply to your specific history:

□ motor vehicle accidents	□ Smoking	□ Heart Disease
□ surgeries	□ Drug use	□ ↑Blood Pressure
□ Injuries/Broken bones	□ Mental Illness	□ Neurological disorder
□ Sports Injuries	□ Diabetes	□ Pregnancy
□ Work Injuries	□ Cancer	□ other _____

Family History
Please check any boxes that apply to anyone in your Family (not including you)
□ Heart conditions □ Cancer □ Diabetes □ Epilepsy □ Other _____

Current Complaint
What is your chief complaint today? _____
Can you describe the pain? _____
When did this start? _____
What makes it worse? _____
What makes it better? _____
Do you have numbness or tingling? Where? _____
Do you have pain shooting down your legs or arms? Where? _____
Has this happened before? When? _____
Please check any of the following that have been an issue within **6 months**:

□ Headaches	□ Chest pain	□ upper back pain	□ Cold hands/feet
□ Low Energy	□ Digestive problems	□ leg pain	□ Carpal tunnel pain
□ Poor sleep	□ Menstrual cramps	□ foot problems	□ ear infections
□ Fatigue	□ Sciatica	□ dizziness	□ weight loss
□ Low back pain	□ Thyroid problems	□ tinnitis	□ pain getting worse

Medications: What medications are you currently taking? For how long? _____
_____

Current Health

Do you take any Nutritional Supplements? Y / N Which ones? _____
_____

Have you seen a Chiropractor before? Y / N
How many of hours of sleep do you normally get per night? _____
What exercise do you get each week? _____
How would rate your diet on average (circle) poor **1 2 3 4 5 6 7 8 9 10** great
How would you rate you stress levels (circle) low **1 2 3 4 5 6 7 8 9 10** high
Do you have any current health goals? _____
_____
Do you have any health concerns you want to talk to the Doctor about? _____
_____

Do you currently wear an orthotic shoe insert? _____

Patient Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Witness: _____