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Norwood Chiropractic Centre

INFORMATION ABOUT YOU: Date: _____

MHSC REGISTRATION # (6 DIGIT) _____ **(9 DIGIT)** _____

AS IT APPEARS ON YOUR MHSC CARD

First Name: _____ Last Name: _____

Birthday (dd/mm/yyyy) ____/____/_____ Current Age: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Home #: _____Work: _____ Cell: _____ Emergency: _____

Email address: _____

Occupation: _____ Employer: _____

Marital Status: ☐M ☐ S ☐ D ☐ W Spouse's Name: _____

# of children: ____ Ages of children: _____

Are you pregnant: ☐Yes ☐No

Who can we thank for referring you to our office? _____

Do you have extended health insurance through Great West Life or Blue Cross? _____

Will you be claiming: Autopac (MPI) ☐Y ☐N Worker's Compensation) ☐Y☐ N
If yes: Injury/Accident Date: _____ **Personal Injury Claim #** _____

CHIROPRACTIC HISTORY:

Have you been to a chiropractor before? ☐Y ☐N Date of last visit: _____
Name of last chiropractor: _____
What are your health goals: ☐ Symptom Relief ☐Wellness Care☐100% Maximized Healthy Living

MAJOR HEALTH CONCERN – PLEASE FILL IN ALL AREAS : IF NOT APPLICABLE PUT "N/A"

What condition brought you to our office? _____
_____
On a scale of 1-10 (10 being severe), how bad is the problem? ____/10
When did it start? _____ How? _____
Is it ☐ getting better ☐ getting worse ☐ staying the same
How would you describe the problem? _____
Are you taking medication for this condition? ☐Y☐N
If yes, which medication: _____Dose: ___
Please list ALL other medications you are currently taking: _____
_____
_____
Please list all surgeries you have had: _____

Your Health History

Please check the boxes for all conditions that apply:

- ☐ Migraine
- ☐ Headache
- ☐ Neck pain
- ☐ Jaw Pain/TMJ/RL
- ☐ Numb/Tingling in hand/arm
- ☐ Upper back pain
- ☐ Shoulder pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Hip Pain
- ☐ Numb/Tingling in leg/feet
- ☐ Foot Pain
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Diabetes
- ☐ Swollen/Painful Joints
- ☐ Frequent Colds/Flu
- ☐ Cancer
- ☐ Convulsions/Epilepsy
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Trouble
- ☐ Stroke
- ☐ Depression
- ☐ Irritable
- ☐ Mood Changes
- ☐ Anemia
- ☐ Tremors
- ☐ Allergies
- ☐ Heartburn
- ☐ Impotence
- ☐ Sexual Dysfunction
- ☐ Prostate Problems
- ☐ PMS
- ☐ Menstrual Problem
- ☐ Menopausal Problems
- ☐ Bed Wetting
- ☐ Hepatitis (A,B,C)
- ☐ HIV/AIDS
- ☐ Sinus Problems
- ☐ Eating Disorders
- ☐ Trouble Sleeping
- ☐ ADD/ADHD
- ☐ Learning Disability
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Hearing Loss
- ☐ Fainting
- ☐ Loss of Balance
- ☐ Blurred Vision
- ☐ Ulcers
- ☐ Kidney Trouble
- ☐ Ear Infections
- ☐ Double Vision
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Varicose Veins
- ☐ Liver Trouble
- ☐ Gall Bladder Trouble
- ☐ Digestive Problems
- ☐ Colon Trouble
- ☐ Diarrhea/Constipation
- ☐ Skin Problems

Please fill out the following information on the above most serious conditions:

Condition 1: _____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/10

When did it start? _____ How? _____

Is it ☐ getting better ☐ getting worse ☐ staying the same

How would you describe the problem? _____

Are you taking medication for this condition? ☐Y ☐N

If yes, which medication: _____Dose: ___

Condition 2: _____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/10

When did it start? _____ How? _____

Is it ☐ getting better ☐ getting worse ☐ staying the same

How would you describe the problem? _____

Are you taking medication for this condition? ☐Y ☐N

If yes, which medication: _____Dose: ___

Condition 3: _____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/10

When did it start? _____ How? _____

Is it ☐ getting better ☐ getting worse ☐ staying the same

How would you describe the problem? _____

Are you taking medication for this condition? ☐Y ☐N

If yes, which medication: _____Dose: ___