MISSISSIPPI CHIROPRACTIC

Dr. Robert Earle *Dr. Nicola Legate*

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PERSONAL INFORMATION

Name: _____

Address:_____City:_____Prov: _____

Postal Code:_____Home Phone#:_____Work:_____Mobile#: _____

Birthdate:_____Age:_____How old do you feel?_____

Occupation:_____Email address _____

Spouse's Name: _____Number of children _____

Family Physcian_____Surgery Phone # _____

Who referred you to our clinic? _____

HEALTH INFORMATION

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

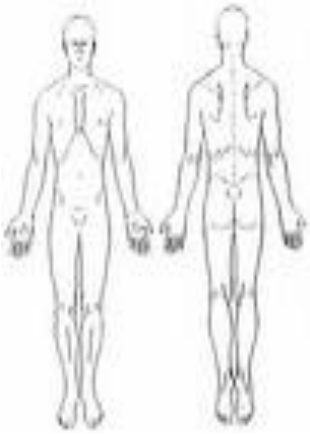
What is your major complaint? _____

How did this problem begin? (fall,lifting etc) _____

How long have you had this condition?_____ Have you had previous episodes? _____

If you are in pain is it? **SHARP DULL ACHE CONSTANT THROBBING BURNING INTERMITTENT**

Indicate on the diagram the areas of discomfort



Does the pain radiate/travel anywhere? **YES/NO**

Since the condition began is it getting **WORSE, BETTER** or **STAYING THE SAME?**

What makes it worse **STANDING WALKING SITTING SLEEPING BENDING LIFTING**

On a scale of 1- 10 how would you rate your pain level?

1(mild)_____10(severe)

This condition is interfering with (circle**) Work Leisure Sleep Exercise Hobbies Other**
Have you had involvement in other healthcare? **Physiotherapy Massage Acupuncture Naturopathy**

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GENERAL HISTORY

Please check any of the following health condition you have ever had, even if they are not related to your current condition:

☐ alcoholism	☐ diabetes	☐ constipation	☐ eczema/psoriasis	☐ cancer
☐ tuberculosis	☐ polio	☐ thyroid	☐ kidney stones	☐ osteoporosis
☐ stomach ulcers	☐ measles	☐ anemia	☐ heart disease	☐ allergies
☐ emphysema	☐ fatigue	☐ pneumonia	☐ multiple sclerosis	☐ infertility
☐ cold sores	☐ asthma	☐ epilepsy	☐ high blood pressure	☐ irritable bowel
☐ cirrhosis of liver	☐ depression	☐ migraines	☐ venereal disease	☐ menstrual pain/cysts
☐ ADHD	☐ stroke	☐ anxiety	☐ rheumatoid arthritis	☐ osteoarthritis
☐ miscarriages	☐ PMS	☐ heartburn	☐ ear infections	☐ sexual dysfunction
☐ severe headaches	☐ Stress			

Are you taking any of the following medications or vitamin supplements?

☐ anti inflammatories	☐ sedatives
☐ muscle relaxants	☐ antibiotics
☐ birth control pills	☐ insulin
☐ thyroid meds	☐ blood pressure meds
☐ pain meds	☐ antacids
☐ anti depressants	☐ anti anxiety
☐ hormones	☐ vitamins/minerals
☐ cholesterol medication	☐ steroids/inhaler (asthma)

Please list all surgeries and/or fractures you have had:

_____Date: _____

_____Date: _____

Have had previous chiropractic care? _____ If so when? _____

Have you had X-Rays taken? _____If so when? _____

Did you have any serious childhood illnesses? _____

Did you have any serious falls or accidents /MVA? _____

Do you engage in regular exercise? _____

Are you a smoker? **Yes** ☐ **No** ☐

Are you pregnant? **Yes** ☐ **No** ☐

"Attitude is a little thing that makes a big difference"

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FAMILY HEALTH PROFILE

Health problems can be hereditary. Information about your immediate family members will give us better picture of your overall health. (ie stroke, heart attack, cancer)

Please circle below your family health history:

	Cancer	Heart	Asthma	Arthritis	Stroke	HBP	Other
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐

MVA/WSIB

If your present complaint is due to a work related injury or a motor vehicle accident and you have/will be submitting a claim, please let the office know.

I hereby authorize Dr. Robert Earle, Dr. Nicola Legate and whomever he/she may designate as their assistants, to release relevant health records, reports and x rays to other health care professionals.

Signature : _____ Date : _____