

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? _____ Marital Status: M S W D

Occupation: _____ Email address _____

Spouse's Name: _____ Number of children _____

Family Physician _____ 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.

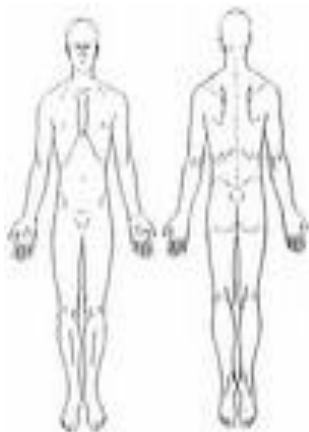
What is your major complaint? _____

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**

GENERAL HISTORY

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

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

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

- | | |
|---|--|
| <input type="checkbox"/> anti inflammatories | <input type="checkbox"/> sedatives |
| <input type="checkbox"/> muscle relaxants | <input type="checkbox"/> antibiotics |
| <input type="checkbox"/> birth control pills | <input type="checkbox"/> insulin |
| <input type="checkbox"/> thyroid meds | <input type="checkbox"/> blood pressure meds |
| <input type="checkbox"/> pain meds | <input type="checkbox"/> antacids |
| <input type="checkbox"/> anti depressants | <input type="checkbox"/> anti anxiety |
| <input type="checkbox"/> hormones | <input type="checkbox"/> vitamins/minerals |
| <input type="checkbox"/> cholesterol medication | <input type="checkbox"/> 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**

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 : _____