

Full Potential Chiropractic

New Patient Information

Personal Information

Name: _____ Hm # _____ Wk # _____ Cell # _____
Address _____ Postal Code: _____
Birth date: month _____ day _____ year _____ Age _____ Sex: M / F
Occupation _____ E-mail Address _____

Alberta Health Care # _____

Do you have health care benefits for Chiropractic? Yes No

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

Is this assessment for the whole family? Family Self

Is this injury the result of a motor vehicle accident or work related accident?

If Yes, please list: _____

Have you had previous chiropractic care? Yes No Doctor's name: _____ How long ago? _____

Have you received X-rays in the last 2 yrs? Yes No Area x-rayed _____

Name of Family Medical Doctor _____ Others seen for this condition _____

Please check any of the following that currently apply to you.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Chronic Fatigue syndrome |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> ADHD | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Seizures | <input type="checkbox"/> TMJ/Jaw Pain |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> MS |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Fibromyalgia |
| Pins & Needles in:
<input type="checkbox"/> legs/feet <input type="checkbox"/> arms/hands | <input type="checkbox"/> Lack of / low energy
<input type="checkbox"/> Poor Awakening | Numbness in:
<input type="checkbox"/> Feet/Toes <input type="checkbox"/> Hands/fingers | <input type="checkbox"/> Auto-immune system disorders
<input type="checkbox"/> Epstein-Barr syndrome |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Buzzing/ringing ears | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Loss of Taste/Smell | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Neck Pain/stiffness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Allergies | <input type="checkbox"/> Rheumatoid Arthritis |

Your Injury History

1. What is your major reason for consulting our office? _____
2. How long has this been going on? Days Weeks Months Years
3. What specific life activities does it interfere with (work, sleep, leisure, etc.)? _____
How did it originally occur? _____
Has it become worse recently? Yes No Same Better Gradually Worse
If yes, when and how? _____
4. How frequent is the condition? Constant Daily Intermittent Night Only
5. Is there anything you can do to relieve the problem? Yes No
If yes, describe _____
If no, what have you tried to do that has not helped? _____
6. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting
Other _____
7. Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing
Other _____
Does the pain travel or radiate? Yes No If Yes, where? _____
8. Are there other unrelated health problems? Yes No If yes, describe _____

9. Have you had any broken bones? Yes No Please list _____
10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes No If yes, please explain _____
11. To your knowledge, is there a family history of cancer, stroke, diabetes, heart disease or a spinal condition? Yes No. If yes, please explain _____
- _____
11. List any medications you are taking: _____

Please place an "X" on the line below to indicate level of problem.

NO
SYMPTOMS 0 |-----| 10 SYMPTOMS EXTREME

Your Health Profile

Spinal subluxations have a significant impact on your health and well-being. Please answer the following important questions to the best of your ability, in as much detail as possible.

Physical Stress

- Yes No Have you ever been involved in a motor vehicle accident (even if you were not injured)?
If yes, please describe: _____
- Yes No Have you had any falls or accidents (especially hard falls, sports/car accidents, concussions, Broken bones, etc.)? If yes, please list all: _____
- Yes No Do you currently play any sports?
Yes No Have you had any sports injuries?
If yes, please describe: _____
- Yes No Were you under regular Chiropractic care as a child?
Yes No Does your job require lifting, repetitive motions, or excessive standing or sitting?
Yes No Have you had any surgeries? Please list all: _____

Chemical Stress

- | | | | |
|------------------------------|-----------------------------|--|--------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do/did you smoke? | How many per day? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do/did you drink alcohol | How many per week? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you drink coffee? | How many per day? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you drink pop? | How many per week? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you eat out frequently or eat excessive amounts of junk food? _____ | |

Please list any drugs you are presently taking (prescription, non-prescription, otherwise): _____

Emotional Stress

On a scale from 1 (best) → 10 (worst), rate your current stress level of the following:

Work _____ Home _____ Financial _____ Other _____

Please describe the following as either poor, fair, good or excellent:

Diet _____ Exercise _____ Sleep _____ General Health _____

Doctor's Notes: _____

Doctor's Signature _____ Date _____