Mckenzie Lake Chiropractic

& Massage Therapy

First Name: Last Name: Sex: □ Male

Date of Birth: Day Month Year Age: □ Female

Height: Weight: Alberta Health Care #:

Address: City: Postal Code:

Phone Numbers: Home: Cell: Work:

Occupation: Email Address:

Source of Referral: □ Person □ Google □ Sign □ Flyer □ Other:

Is this injury the result of a Motor Vehicle Accident: □ Yes / □ No …or Work-related Accident: □ Yes / □ No

Previous and Current Treatment with other Practitioners:

Chiropractic □ No / □ Yes: □ Past / □ Current Name: _____

Physiotherapy □ No / □ Yes: □ Past / □ Current Name: _____

Massage Therapy □ No / □ Yes: □ Past / □ Current _____

X-rays / MRI / CT Scan □ No / □ Yes: Test Type, area & date: _____

*(within last 2 years)

Family Doctor Name: Others seen for this condition:

Emergency Contact Name: Emergency Contact Number:

Do you have Health Benefits that cover Chiropractic and Massage Therapy? □ No □ Yes:

□ Sleeping Problems	□ Dizziness	□ Headaches	□ Bowel Problems	□ Fevers
□ Hypoglycemia	□ Heartburn	□ Chronic Fatigue	□ High/Low Blood Pressure	□ Scoliosis
□ Nervousness	□ ADHD	□ Hot Flashes	□ Lack of / Low Energy	□ Constipation
□ TMJ / Jaw Pain	□ Ulcers	□ MS	□ Poor Concentration	□ Menstrual Pain
□ Frequent Colds	□ Problem Urinating	□ Mood Swings	□ Poor Awakening	□ Fibromyalgia
□ Difficulty Breathing	□ Rheumatoid Arthritis	□ Seizures	□ Buzzing/Ringing in ears	□ Poor Circulation
□ Heart Palpations	□ Irritability	□ Bed Wetting	□ Cold hands/feet	□ Ear Aches
□ Loss of Taste/Smell	□ Panic Attacks	□ Loss of Balance	□ Epstein-Barr syndrome	□ Neck Pain/stiffness
□ Allergies	□ Crohn's	□ Blurred Vision	□ Auto-immune system disorders	□ Depression
Pins & Needles in: □ Legs/Feet □ Arms/Hands	Numbness in: □ Legs/Feet □ Arms/Hands	Diabetes □ Type 1 □ Type 2	Pregnant; □ Yes ___ weeks □ Pregnancies #____	□ Anxiety □ Hyperthyroidism □ Hypothyroidism

What is your reason for consulting our office?

How long has this been going on? □ Days □ Weeks □ Months □ Years

How did it originally occur?

What specific activities does it interfere with (work, sleep, leisure, etc.)?

Has it become worse recently? □ Yes □ No □ Same □ Better □ Gradually Worse

If Yes, When and How?

How frequent is the condition? □ Constant □ Daily □ Intermittent □ at Night Only

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?

What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting □ Other:

Describe the pain: □ Sharp □ Dull □ Numbness □ Tingling □ Aching □ Burning □ Stabbing □ Other:

Does the pain travel or radiate? □ No □ Yes; Where:

Do you have other unrelated health problems or issues? □ No □ Yes, please list:

(i.e. sensitive skin, asthma, cancer, etc.)

Have you had any broken bones? □ No □ Yes, please list:

To your knowledge is there a family history of cancer, stroke, diabetes, heart disease or a spinal condition?

□ No □ Yes, please explain:

List any medications you are taking:

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

NO SYPTOMS 0 ----------10 EXTREME SYMPTOMS

Spinal Restrictions have a significant impact on your health and well-being. Please answer the following important questions to 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 accidents, concussions, broken bones, etc.)? If Yes, please describe:

□ Yes □ No Do you currently play any sports? If Yes, please describe:

□ 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 <u>any</u> surgeries? Please list all:

Nutritional Stress

□ Yes □ No Do you eat 5 – 9 servings of vegetables/fruits daily?

□ Yes □ No Do you take a Multivitamin? If Yes, which brand:

□ Yes □ No Do you supplement with a greens powder? If Yes, which brand:

□ Yes □ No Do you take Omega 3/Fish Oil/Cod Liver Oil? If Yes, which brand:

□ Yes □ No Do you take 4,000 – 5,000 IU of Vitamin D daily? If Yes, which brand:

□ Yes □ No Do you take a Probiotic? If Yes, which brand:

Emotional Stress

On a scale of 1 (best) to 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

Please check this box to **OPT OUT** of emails, health reports, monthly newsletters, special promotions and the latest health information, exercises and recipes. *Note: your email can still be used to send your receipts electronically.

□ Please **exclude** my email address from the above mentioned.

Date: Signature: