Advance Spine and Health

Dr. L. R. Little

Chiropractor

Patient Personal Information

Last Name: _____ First Name: _____

Mailing Address: _____

City/Province:_____Postal Code:_____

Home Phone: _____ Cell Phone: _____

Email: _____

Birthday (DD/MM/YYYY) _____ Male: _____ Female: _____

Health Care Number: _____
Other Medical Insurance: _____

Occupation: _____
Patients Employer: _____
Employers Address: _____
Work Phone: _____

Martial Status (Circle One): S C M D W
Spouse Name: _____ Phone: _____

By whom were you referred to us? _____
Is this a WCB or Motor Vehicle Accident claim? _____
Family Physician_____

I understand that fees are due when services are rendered.
Payment: *We accept cash, debit, Visa and MasterCard.*

Signed: _____ **Date:** _____

File Number _____

The data on this form is confidential and essential if we are to render the best professional care. We appreciate your co-operation in filling out this form so that we will have accurate records. Please Print clearly.

What is your major complaint/concern? _____
What makes it feel better? _____
How long have you had this condition? _____
Have you had this or similar condition in the past? Yes _____ No _____ When? _____
What activities aggravate your condition? _____
Is this condition interfering with your work? _____ Sleep? _____ Daily routine? _____
Other complaints: (Please list) _____
How long has it been since you really felt good? _____
Have your previous chiropractic care? Yes ____ No ____ Which Doctor? _____
Were X-Rays taken? _____Where? _____
Please list any surgical operations and the years they were performed**?** _____
_____
Do you or any one in your family have Heart disease? _____
Do you or any one in your family have Diabetes? _____
Are you currently taking any medications? _____

Such as:

Birth Control _____	Muscle Relaxants ____	Insulin _____	Nerve Pills _____
Pain Killers_____	Pep Pills _____	Tranquilizers _____	Vitamins _____

What type of mattress do you sleep on? Firm? _____ Soft? _____
How do you sleep? On back? ____ On side? ____ On stomach? ____ A combination? ____
Do you wear heel lifts? ____ Sole lifts? ____ Inner soles? ____ Arch supports? ____
Have you ever been in an auto accident? Yes ____ No ____ If so, when? _____
Have you ever had any other personal injury? Example: broken bones, concussion, fall
Past year? ____ Past 5 years? ____ Over 5 years? ____ None ____
Interests and Hobbies? _____

Many health problems are the result of hereditary spinal weaknesses. This information about your immediate family members will give us a better picture of your total health. Have you or a <u>Family Member</u> have a history of the following: (Please check off)

Alcoholism	Cancer	Hyperactivity	Schizophrenia
Allergies	Cardiovascular Disease	Lumbago	Stomach Ulcers
Arthritis	Depression	Learning Disability	Venereal Disease
Asthma	Diabetes	Multiple Sclerosis	

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis. Treatment plan and possibility of being accepted for care.

Check off any of the following diseases that you have or had in the past:

Alcoholism	Diabetes	Lumbago	Pneumonia
Anemia	Diphtheria	Malaria	Polio
Appendicitis	Eczema	Measles	Rheumatic Fever
Arthritis	Epilepsy	Mental Disorder	Scarlet Fever
Cancer	Goiter	Mumps	Tuberculosis
Chicken Pox	Heart Disease	Pleurisy	Typhoid Fever
	Influenza		Whooping Cough

Check off any symptoms you have experienced in the last 6 months:

Musculo-Skeletal

Low Back Pain
Gas/Bloating after meals
Pain between shoulders
Heartburn
Neck Pain
Black/Bloody Stool
Arm Pain
Colitis
Joint Pain/Stiffness
Walking Problems
Difficulty Chewing/Clicking Jaw

Nervous System

Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/Depression
Fainting
Convulsions
Cold/Tingling Extremities
Headaches

Gastro-Intestinal

Poor/Excessive Appetite
Gall Bladder Problems
Abdominal Cramps/IBS
Excessive Thirst
Nausea, Vomiting
Constipation/Diarrhea
Crones/Colitis
Hemorrhoids
Liver Trouble
Weight Trouble

Cardiovascular/Respiratory

Chest Pain
Short of Breath
Blood Pressure Problems
Irregular Heartbeat
Lung Problems/Congestion
Varicose Veins
Ankle Swelling

Ears/Eyes/Nose/Throat

Vision Problems
Dental Problems
Sore Throat
Ear Aches
Hearing Difficulty
Stuffed Nose

Genito-Urinary Bladder Trouble

Painful/Excessive Urination
Discolored Urine

General

Allergies
Loss of Sleep
Fever Headaches

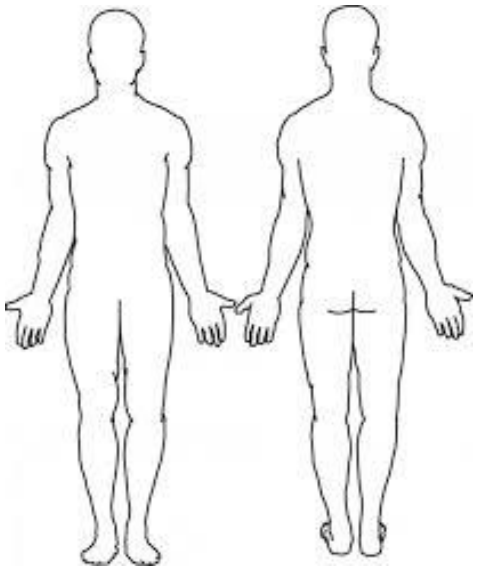
Females/ Female Menstrual

When was your last period?
Are you Pregnant? Yes____ No____
Maybe____
Irregular Menses
Cramping, Vaginal Pain/Infection
Breast Pain/Lumps
Sexual Dysfunction

Males

Prostate
Sexual Dysfunction

Please indicate on the diagram the area of your discomfort



Patient Accepted: Yes No

Doctor's Signature _____