Date: File #:

Langs Chiropractic

Sex:

First Name: Last Name: Home Phone #:

Date of Birth (D/M/Y) : / / Email Address

Home Address: Postal Code

Occupation: Business Address: Bus. Phone #:

Marital Status: Name of Partner:

Family Physician: Is it ok to send your physician updates regarding your condition?
Yes No

Have you seen a chiropractor before? Yes No Name: How long ago? _____

How did you hear about our office: Referred by:

Is your injury: __ Work Related? Has injury been reported to your employer? Yes No WSIB? Yes No
__ From a motor vehicle accident?
__ Personal Injury
__ Other

Current Medications: _____
Previous X-rays: Yes No If yes, when and where were they taken? _____
Have you had any recent blood work? __ Yes __No Results:_____
Approximate date of your last physical examination: _____ Results: _____

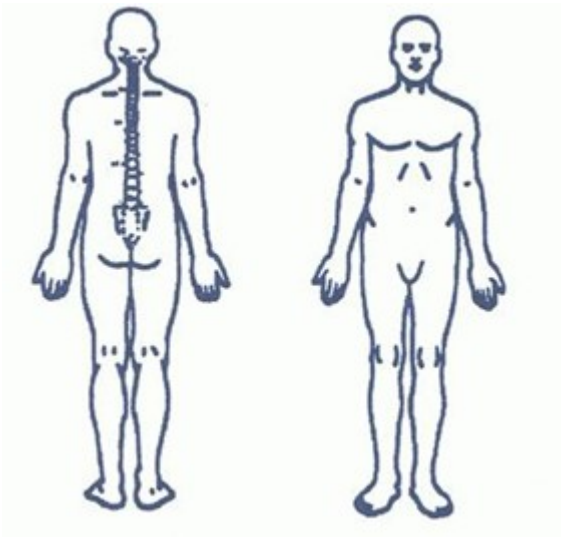
Within the past 6 months:			
	Have you had any infections and/or fever?	Yes	No
	Have you had any weight gain or loss?	Yes	No
	Have you had pain that has woken you up at night?	Yes	No

Exercise: None Moderate Daily
Current Sports: _____
Approximate body weight: _____

Do you smoke? Yes No Packs/day: _____
Do you drink alcohol? Yes No Drinks/day: _____

Please indicate your area of your symptoms on this diagram using the symbols listed below:

+++++	Dull and Aching
//////////	Stabbing or Sharp
=====	Stiff and Tight
XXXX	Burning
NNNN	Numbness
******	Pins and Needles



Family History of:

__Diabetes
__Cancer
__Back Problems
__Heart Disease

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Have you had any of the following diseases?

☐ Cancer	☐ Appendicitis	☐ Pneumonia	☐ Rheumatic Fever
☐ Rheumatoid Arthritis	☐ Polio	☐ Tuberculosis	☐ Whooping Cough
☐ Stroke	☐ Measles	☐ Mumps	☐ Chicken Pox
☐ Diabetes	☐ Heart Disease	☐ Thyroid Disorder	☐ Influenza
☐ Pleurisy	☐ STD/venereal disease	☐ Epilepsy	☐ Eczema
☐ AIDS	☐ Mental Disorder	☐ Anemia	☐ Other _____

Have you ever been in a motor vehicle accident? □ Yes □ No Details:_____
Have you ever had any broken bones/fractures? □ Yes □ No Details:_____
Have you ever been hospitalized? □ Yes □ No Details:_____

Please read the following list carefully. Circle the symptoms you are presently experiencing and place a check mark ✓ beside symptoms you have had in the past.

Low Back Problems
Pain between shoulders
Neck problems
Arm problems
Shoulder problems
Swollen joints
Painful joints
Stiff joints
Muscle spasms
Weak muscles
Spinal Curvature
Hernia
Sciatica

Sleep Problems
Numbness
Nervousness
Allergy
Dizziness
Fainting
Headaches
Fatigue
Convulsions
Fever
Confusion
Depression

Chest Pain
Pain over heart
Difficult breathing
Persistent cough
Coughing phlegm
Coughing blood
Rapid heartbeat
Slow heartbeat

Heart problems
Lung problems
Varicose veins
Asthma

Poor appetite
Excessive Hunger
Excessive thirst
Nausea
Vomiting food
Vomiting blood
Abdominal Pain
Diarrhea
Constipation
Colon problems
Bloody stool
Hemorrhoids
Liver problems
Gallbladder problems
Excessive weight loss
Obesity

Loss of bladder control
Frequent urination
Kidney infection
Painful urination
Discoloured urine
Prostate problems
Bed wetting

Eye pain
Eye inflammation
Earache
Ear noises
Hearing loss

Ear discharge
Sinus infection
Nose bleeding
Nose discharge
Thyroid problems
Dental problems
Sore gums
Hoarseness
Tonsillitis
Bruise easily

Female Only
Pregnancy
Previous miscarriage
Vaginal discharge
Excessive bleeding
Painful menstrual periods
Breast pain
Breast lumps
Irregular cycles
Menopausal symptoms
Length of time since beginning of last menstrual period:
_____

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