spineworks CHIROPRACTIC

▲ Patient ID ▲ Date (YYYY-MM-DD)

INFORMATION

▲ Family name ▲ First name

▲ Date of birth (YYYY-MM-DD) ▲ Address

▲ City ▲ Postal code

▲ Home phone ▲ Mobile phone ▲ Email

▲ Occupation ▲ Referring physician

Gender ◯ Female ◯ Male

cm kg
▲ Age ▲ Height ▲ Weight

Do you have children? ◯ No ◯ Yes ▲ Age

Civil status ◯ Single ◯ Partnered *

▲ *First and last name

Have you ever seen a chiro? ◯ Y* ◯ N

▲ *First and last name

Do you have insurance which covers chiropractic treatments? ◯ No ◯ Yes

▲ Insurance company

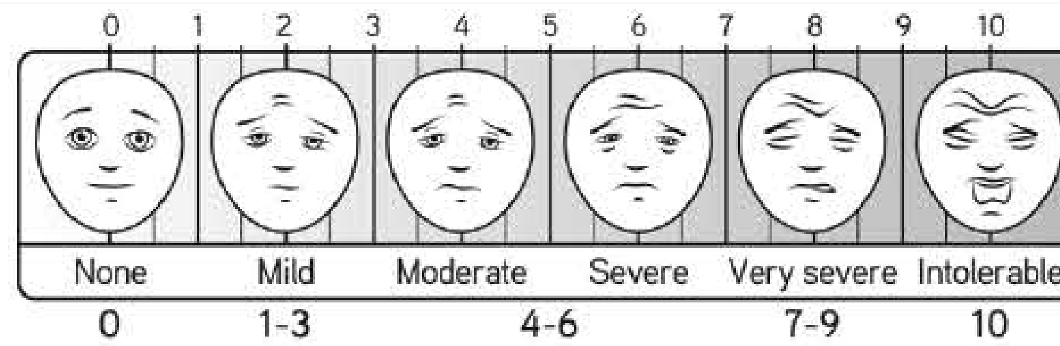
Who referred you to us?

◯ Friend* ◯ kenningtonchiropractic.com ◯ Sign / Local ◯ Insurance ◯ Family* ◯ Facebook ◯ GP* / Therapist* ◯ Other* ▲ *Specify

REASON FOR THE CONSULTATION

List the reasons for your consultation by order of importance.

Pain scale:



1.

Pain ▼ 0 1 2 3 4 5 6 7 8 9 10 Since

2.

Pain ▼ 0 1 2 3 4 5 6 7 8 9 10 Since

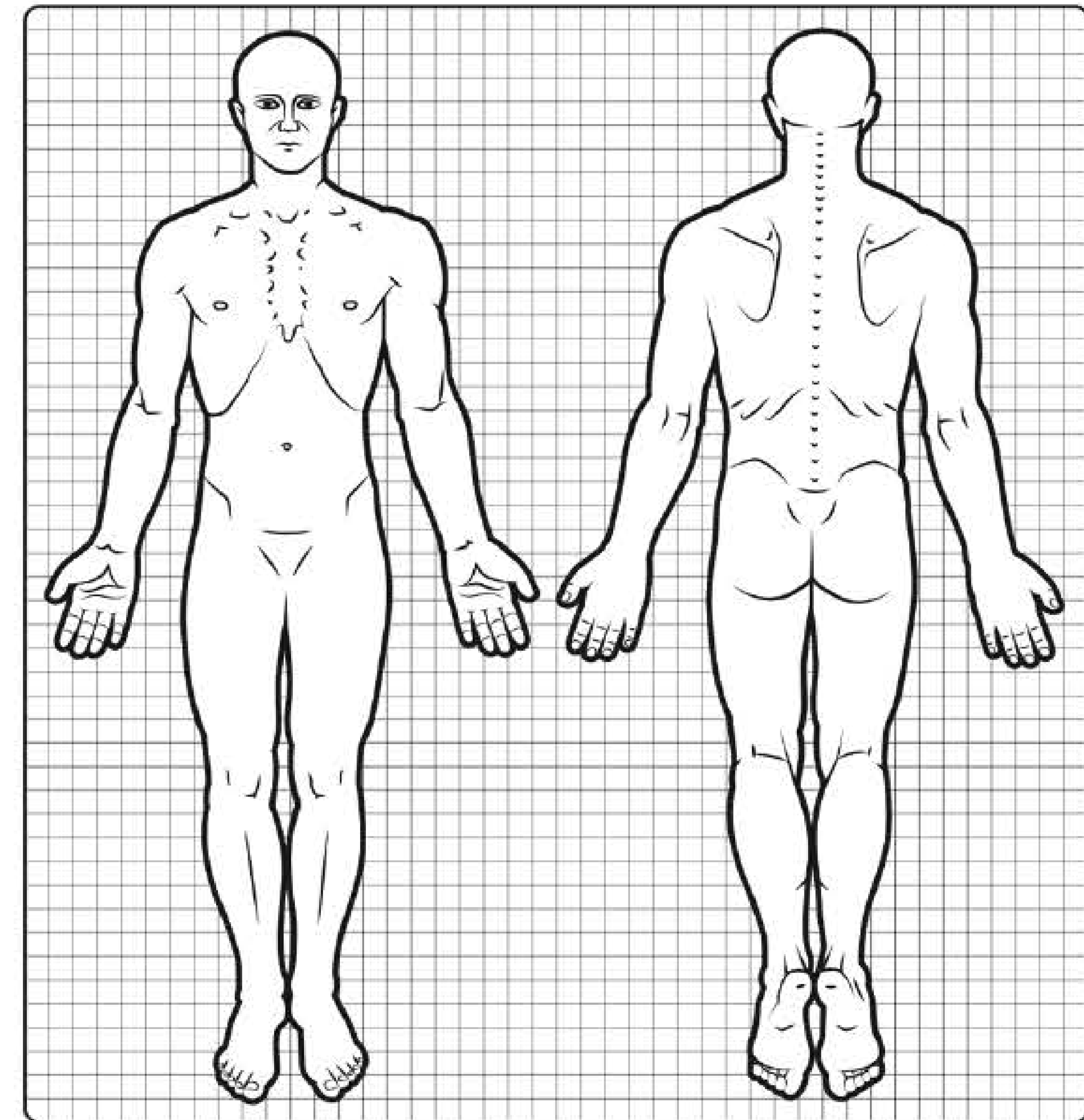
3.

Pain ▼ 0 1 2 3 4 5 6 7 8 9 10 Since

Is the pain spreading? ◯ No ◯ Yes, up to

What other healthcare professionals have you consulted for these conditions?

1. 2.



Locate the reasons for your consultation (already listed at left) on the diagram by **circling** the affected area.

Do you have headaches? ◯ N ◯ Yes

PERSONAL HISTORY

List your history of injuries/accidents/fractures

1. Date
2. Date
3. Date
4. Date
5. Date

Please rate your stress level.
(0: no stress; 10: extreme stress)
0 1 2 3 4 5 6 7 8 9 10

Main source of stress.

Do you do any physical activities/sports?

▲ Specify ▲ Hours/week

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History of surgeries and hospitalizations.

1. ____________________

2. ____________________

Cigarette consumption.

☐ No ☐ Yes ▶ ________ /week

Alcohol consumption.

☐ No ☐ Yes ▶ ________ /week

What is your working position?

☐ Standing
☐ Sitting ______ Hours/week
☐ In motion

Usually, you sleep on...

☐ Your back
☐ Your side
☐ Your stomach

What are your expectations for treatment?

☐ Relief
☐ Correction
☐ To optimize health

FAMILY MEDICAL HISTORY

Does a member of your family suffer from:

☐ Diabetes ☐ High cholesterol ☐ Heart disease ☐ Hyperkyphosis ☐ Osteoporosis
☐ Cancer ☐ Osteoarthritis/arthritis ☐ Hereditary disease ☐ Scoliosis ☐ Other ▶ ____________________

MEDICAL HISTORY

Please check off the physical ailments you are experiencing/have experienced.

SEVERE ILLNESSES

☐ Cancer
☐ Hypertension
☐ Stroke
☐ Diabetes

MUSCULOSKELETAL SYSTEM

☐ Back pain
☐ Pain between shoulder blades
☐ Neck pain
☐ Pain in the arms/hands
☐ Pain in the legs/feet
☐ Joint stiffness
☐ Difficulty walking
☐ Scoliosis
☐ Hyperkyphosis
☐ Arthritis/osteoarthritis
☐ Osteoporosis

IMMUNE SYSTEM

☐ Ear infection
☐ Sinusitis
☐ Recurring infections

GENITOURINARY SYSTEM

☐ Urinary tract infection
☐ Frequent/excessive urination
☐ Prostate disorder
☐ Urinary loss
☐ Incontinence
☐ Menstrual pain
☐ Breast pain/lump
☐ Menopause
☐ Pregnant ▼

____
▲ Date of your last period

NERVOUS SYSTEM

☐ Numbness
☐ Muscle weakness
☐ Dizziness/vertigo
☐ Fainting
☐ Epilepsy
☐ Mental disorder
☐ Ear noise

GENERAL

☐ Insomnia
☐ Fatigue
☐ Thyroid disorder
☐ Anxiety/depression
☐ Allergies*

____
▲ *Specify

GASTROINTESTINAL SYSTEM

☐ Digestive problems
☐ Food intolerance
☐ Irritable bowel syndrome
☐ Diarrhea
☐ Constipation
☐ Bloating
☐ Heart burn
☐ Excessive weight gain or loss
☐ Nausea ☐ Vomiting
☐ Blood in stools

SKIN

☐ Eczema
☐ Psoriasis

RESPIRATORY SYSTEM

☐ Asthma
☐ Bronchitis
☐ Difficult breathing

CARDIOVASCULAR SYSTEM

☐ Chest pain
☐ Heart problems
☐ Edema
☐ Cold extremities
☐ Varices
☐ High cholesterol
☐ High blood pressure
☐ Low blood pressure
☐ Bleed easily

____
▲ Any other health issues

Do you take any medications? ☐ N ☐ Y*

____
▲ *For which of the above conditions? (or circle)

Do you take any dietary supplements? ☐ N ☐ Y*

____
▲ *Specify?

When was your last medical check up ?

____

DECLARATION (mandatory for all)

I declare that all information provided in this form is complete and acurate and agree to undergo any required medical examinations.

____________________ ▲ Signature ________ ▲ Date

PRACTITIONER USE ONLY

I have been given a report of finding regarding my condition. i have been advised of, and understood, the possible risks of treatment and had all my questions answered to my satisfaction. I consent to the treatment as outlined to me

____________________ ▲ Signature ________ ▲ Date ____________________ ▲ Legal guardian

THERAPY PATIENTS : I consent to have Massage therapy

____________________ ▲ Signature ________ ▲ Date