

Nantais Family Chiropractic
Confidential Adult Patient Information Record

Patient Name _____ Address _____
City _____ Province _____ Postal Code _____
Home Phone _____ Email _____
Birth Date (D/M/Y) _____ Age _____ Gender M ___ F ___ Status M_ S_ W_ D_
Business/Employer _____ Type of work _____
Business phone _____
Emergency Contact _____ Phone _____ Relationship _____
Spouse's Name _____ Children's ages _____
Whom shall we thank for referring you to our office? _____

Why is this form important? As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. This patient information form will uncover any layers of damage, especially to your nervous system, allowing us to better assess any challenges to your health potential and then along with an examination, to outline a course of care so you may reach your health destiny.

If you have no specific symptoms or complaints and are here mainly for wellness services, please check here _____.

If you have symptoms, please briefly describe: primary _____;
secondary _____.

Since the primary problem started, is it: About the same ___ Getting better ___ Getting worse ___
What makes it worse?

_____.

What relieves this condition?

_____.

It interferes with: Work ___ Sleep ___ Walking ___ Sitting ___ Hobbies ___ Leisure ___

How long have you had this condition? _____ Have you had a similar condition in the past? Y___ N___

If you are experiencing pain, is it: Sharp ___ Dull ___ Travels ___ Constant ___ Intermittent ___ Burning ___

Throbbing ___ Tight ___

Are you getting pain(P)and/or numbness (N)in: Arms L___ R___; Hands L___ R___; Legs L___ R___;

Feet L___ R___; Buttocks L___ R___; Head ___

Is this pain/numbness getting progressively worse? Y ___ N ___. Is it constant? Y ___ N ___. Does it come/go? Y ___ N ___

Have you had previous chiropractic care? Y___ N___ Why? _____

When? _____ Were X-rays taken? Y ___ N___

Chiropractor's name _____

Please rate your level of commitment to resolving this/these problem(s) (10 being the highest):

1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

History:

1. Were you involved in any car accidents: as a child N __ Y __ Age? ____ Describe any injuries? ____

Were you involved in any car accidents as an adult N __ Y __ Age? ____ Were you the driver? __
passenger? __ Injuries: Describe _____
Other __ Age? ____ Were you the driver? __
passenger? __ Injuries: Describe _____
2. Have you fallen/jumped from a height over 3 feet: as a child? N __ Y __ Age? ____ Any injuries?
Describe _____
Have you fallen as an adult? N __ Y __ Age? ____ Any injuries? __ Describe _____
3. Have you had any surgeries as a child? N __ Y __ Age? ____ Describe _____
Have you had any surgeries as an adult? N __ Y __ Age? ____ Describe _____
Other __ Age? ____ Describe _____
4. Did you take any drugs as a child? N __ Y __ Describe _____
Drugs you presently take: Anti-inflammatory__ Pain Killers__ Muscle Relaxers__ Blood Pressure__
Tranquilizers__ Insulin__ Birth Control__ Other: _____
5. On a scale of 1-10 rate your stress level (1=none, 10=severe) Occupational ____ Personal ____
6. Were you delivered: Naturally__ C-section__ Forceps__ Vacuum__ Mom induced__ Breech__ Unsure __
7. Did you suffer any sports traumas? N __ Y __ When? _____ What? _____
8. Did you suffer any work traumas? N __ Y __ When? _____ What? _____
9. Were you vaccinated as a child? N __ Y __
10. Did you have any childhood illnesses? N __ Y __ What/When? _____
11. Female patients-is there a possibility that you are pregnant? Y __ N __ Trying __ Unsure __ Date of last
menstrual period _____.

Please check off ALL of the following if you have this NOW or in the PAST:

- | | | |
|---|-------------------------------------|----------------------------------|
| N __ P __ Loss of sleep | N __ P __ Pinched nerves | N __ P __ Gall bladder problems |
| N __ P __ Dizziness | N __ P __ Low back pain | N __ P __ Diarrhea |
| N __ P __ Fatigue | N __ P __ Hip pain | N __ P __ Constipation |
| N __ P __ Confusion | N __ P __ Walking problems | N __ P __ Bladder problems |
| N __ P __ Forgetfulness | N __ P __ Morning stiffness | N __ P __ Painful urination |
| N __ P __ Imbalance | N __ P __ Buzzing/ringing in ears | N __ P __ Thyroid problems |
| N __ P __ Migraines | N __ P __ Chronic infections | N __ P __ Diabetes |
| N __ P __ Neck pain | N __ P __ Decreased immunity | N __ P __ Teeth problems |
| N __ P __ Arm pain | N __ P __ Frequent colds | N __ P __ Eye problems |
| N __ P __ Shoulder pain | N __ P __ Shortness of breath | N __ P __ Hearing problems |
| N __ P __ Pain between
shoulder blades | N __ P __ Heart/vascular problems | N __ P __ Mood swings |
| N __ P __ Leg pain | N __ P __ Heart disease/chest pains | N __ P __ Depression |
| N __ P __ Knee pain | N __ P __ Blood pressure problems | N __ P __ Sexual dysfunction |
| N __ P __ Foot pain | N __ P __ Ankle swelling | N __ P __ Breast pains |
| N __ P __ Arthritis | N __ P __ Frequent nausea | N __ P __ Menstrual irregularity |
| N __ P __ Herniated disc | N __ P __ Ulcers/heartburn | N __ P __ Miscarriage(s) |
| N __ P __ Numbness/tingling | N __ P __ Upset stomach | N __ P __ Osteoporosis |
| N __ P __ Allergies | N __ P __ Liver Problems | N __ P __ Cancer of _____ |

Signature _____ Date _____

