PATIENT APPLICATION

KOHLER CHIROPRACTIC CENTRE
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The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods.

Please complete this confidential health questionnaire fully and accurately. The more we know about the overall picture of your health, the better we will be able to help you.

Doctors of Chiropractic are trained to detect and correct vertebral subluxations. Please respond to this questionnaire thoroughly, to help us determine potential causes and effects of subluxations in your case.

If you have any questions, please don't hesitate to ask our chiropractic assistant for guidance.

EXPERIENCE WITH CHIROPRACTIC CARE

Who referred you to this office? _____

Have you ever been adjusted by another Chiropractor? ❑ Yes ❑ No

Reasons for those visits? _____

_____

Were X-rays taken? ❑ Yes ❑ No

Did your family receive chiropractic care?
❑ Yes ❑ No ❑ N/A

Chiropractor's Name _____

Approximate date of last visit _____

PATIENT INFORMATION

Name _____

Street Address _____

City _____ Postal _____

Telephone _____

Home _____

Work _____

Cell _____

Fax _____

Email _____

S.I.N. _____

Birthdate _____

Age_____Height_____ Weight _____

Gender ❑ Male ❑ Female

Number of Children _____

Marital Status ❑ Single ❑ Married ❑ Separated

❑ Divorced ❑ Widowed ❑ Common Law

Name of Spouse / Significant Other

_____

My Occupation _____

Employer _____

GOALS FOR MY CARE

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for the correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when making recommendations for care. Please check the type of care desired so that we may be guided by your wishes whenever possible:

❑ Relief Care – symptomatic relief of pain or discomfort

❑ Corrective Care – correcting and relieving the cause of the problem as well as the symptoms

❑ Comprehensive Care – bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic adjustments

❑ I want the Doctor to select the type of care appropriate to my health status.

_____ _____

(Signature) (Date)

WHAT IS THE PURPOSE OF THIS APPOINTMENT?

Describe the purpose of this visit _____

_____

_____

Is the purpose of this appointment related to

❑ Work ❑ Stress ❑ Sports ❑ Auto ❑ Fall ❑ Chronic Discomfort ❑ Repetitive Trauma ❑ Check-up ❑ Other

Please explain _____

_____

(for a specific chief complaint, please complete the section immediately below)

How long have you had this condition? _____ Have you had this or similar conditions in the past? (When?) _____

What activities aggravate your condition? _____

_____

Has this condition ❑ gotten worse ❑ stayed constant ❑ comes and goes

Does this condition interfere with ❑ Work ❑ Sleep ❑ Daily Routine ❑ Childcare responsibilities ❑ Sports ❑ Other Activities (explain below)

_____

_____

Have you seen any other health care providers for diagnosis or management of this condition?

❑ Yes ❑ No (If yes, explain below)

Practitioner's Name _____
Type of Care _____
Date _____ Results _____

Practitioner's Name _____
Type of Care _____
Date _____ Results _____

Are you seeking chiropractic care

❑ as primary intervention ❑ in conjunction with other interventions ❑ as a last resort

MY HEALTH CONDITIONS Please check each of the diseases or conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, care plan, and the possibility of being accepted for care or referred to another practitioner, if necessary.

GENERAL
❑ Allergy
❑ Convulsions
❑ Dizziness
❑ Fatigue
❑ Headache
❑ Loss of Sleep
❑ Loss of Weight
❑ Anxiety/Depression
❑ Numbness
❑ Cancer
❑ Diabetes
❑ Thyroid problems
❑ Epilepsy
❑ Hyperactivity

MUSCLE AND JOINT
❑ Arthritis
❑ Hernia
❑ Low back pain
❑ Neck pain
❑ Pain between shoulder blades

NUMBNESS OR PAIN IN:
❑ Shoulders
❑ Upper arms
❑ Hands
❑ Legs
❑ Feet
❑ Poor posture
❑ Swollen joints
❑ Gout
❑ Polio

GASTRO-INTESTINAL
❑ Constipation
❑ Diarrhea
❑ Digestive dysfunction
❑ Gall Bladder trouble
❑ Hemorrhoids
❑ Liver trouble
❑ Ulcers

EYES, EARS, NOSE, THROAT
❑ Frequent Colds
❑ Crossed Eyes
❑ Deafness
❑ Ear infections
❑ Ringing in ears
❑ Eye pain
❑ Vision problems
❑ Nasal obstruction
❑ Sinus infection

CARDIO-VASCULAR
❑ High blood pressure
❑ Low blood pressure
❑ Poor circulation
❑ Irregular heart beat
❑ Ankle swelling
❑ Anemia
❑ Arteriosclerosis
❑ Stroke

RESPIRATORY
❑ Asthma
❑ Chest pain
❑ Chronic Cough
❑ Irregular breathing
❑ Wheezing
❑ Emphysema
❑ COPD

GENITO-URINARY
❑ Bed-wetting
❑ Painful or difficult urination
❑ Prostate trouble
❑ Blood in urine
❑ Venereal Disease

WOMEN ONLY
❑ Menstrual cramps
❑ Excessive menstruation
❑ Irregular cycle
❑ Hot flashes

Are you pregnant?
❑ Yes ❑ No

SOURCES OF SPINAL STRESS

To help us determine the cause of your problem, please indicate, on this page and the next, potential sources of spinal trauma.

GENERAL PHYSICAL TRAUMA FALLS (Details and Dates)

❑ As infant or child _____
❑ Down stairs _____
❑ On ice _____
❑ Sports Impacts _____
❑ Physical fight _____
❑ Other _____

PRIMARY DAILY ACTIVITIES

❑ sitting ❑ standing ❑ walking ❑ desk work ❑ telephone
❑ driving ❑ manual repetitive work ❑ heavy lifting

EXERCISE

❑ heavy/daily ❑ moderate/recreational ❑ periodic
Describe _____

SPORTS AND LEISURE

Were you, or are you active in any sports? ❑ Yes ❑ No
Describe _____

Have you been hurt or injured in any of these activities
❑ Yes ❑ No
Describe _____

BIRTH

With respect to your own birth process, check all that apply:

❑ Natural ❑ Epidural/Drug-induced
❑ Premature ❑ C-section
❑ Breech ❑ Cord around neck
❑ Forceps ❑ Prolonged delivery
❑ Vacuum Extraction ❑ Pulling/twisting by delivery doctor

Did the mother sustain any falls, accidents, or injuries during pregnancy?
❑ Yes ❑ No ❑ Unknown

Conditions experienced immediately following birth:
❑ Jaundice ❑ Feeding Problems ❑ Respiratory Problems
❑ Displaced or Broken Bones ❑ Other _____

Birth location
❑ Home ❑ Birthing Centre ❑ Hospital ❑ Other

AUTO ACCIDENTS

Have you ever, even as a passenger, even if you did not think you were hurt, been involved in car accident, or near collision? ❑ Yes ❑ No

If yes, please indicate approximate dates and severity:
_____
_____

If your chief complaint is in direct response to a motor vehicle accident, please notify our staff, as we will require a separate questionnaire to document your accident and injury.

With respect to the questions below, please provide details where applicable, including dates:

Have you ever been knocked unconscious? ❑ Yes ❑ No _____
_____

Have you ever used crutches, a walker, or cane? ❑ Yes ❑ No _____
_____

Have you had any broken bones? ❑ Yes ❑ No _____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ❑ Yes ❑ No
_____
_____

Have you had extensive dental or orthodontial work performed? ❑ Yes ❑ No _____
_____

Sprains, strains, dislocations and years: _____
_____

Surgical operations and years: _____
_____

Have you ever been hospitalized for any other reason? ❑ Yes ❑ No _____

FAMILY HEALTH HISTORY

Family members with diagnosed health problems _____

_____

HISTORY OF CHEMICAL AND PERSONAL STRESS

Medications I am presently taking

❑ Painkillers _____

❑ Anti-inflammatories _____

❑ Muscle relaxants _____

❑ Blood pressure medication _____

❑ Stimulants, Anti-depressants _____

❑ Tranquilizers, Anti-anxiety _____

❑ Blood thinners _____

❑ Birth control pills

❑ Other _____

_____

_____

HEALTH HABITS

	HEAVY	MODERATE	LIGHT	NONE
Tobacco	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Alcohol	❑	❑	❑	❑
Recreational Drugs	❑	❑	❑	❑
Prescription Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑

PERSONAL STRESS LEVELS

Past	❑	❑	❑	❑
Present	❑	❑	❑	❑

I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary.

In the event that X-rays are necessary in my case, I understand and agree that X-rays taken in this clinic are the property of Kohler Chiropractic Centre, and will remain in this clinic where they can be reviewed for me by the doctors.

I have listed below an emergency and/or alternate contact with whom this office may communicate, if I cannot be contacted personally, or in the caseof an emergency. Under such circumstances only, this office has my consent to identify me as a patient to the contacts named below.

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable.

(Check if applicable:) ❑ I have health coverage and/or accident insurance through _____.

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself.

_____ _____

(Signature) (I have read and understand the above) (Date)

ALTERNATE ADDRESS

❑ Permanent ❑ Temporary ❑ Parent ❑ Not Applicable

Name _____

Address _____ Unit # _____

City _____ Prov _____

Postal _____ Telephone _____

EMERGENCY CONTACT

Name of a relative or close friend <u>not</u> living at my own address(es):

Name _____

Address _____

City _____

Telephone _____