Balanced Chiropractic

your natural health centre

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New Patient Form

Date: _____ Name: _____

Health Care Number: _____ Date of Birth: _____
Day/Month/Year

Address: _____ Phone Number: _____
City: _____ Work Number: _____
Postal Code: _____ Cell Number: _____
Email: _____

Emergency Contact: _____
Emergency Number: _____

Do you have insurance? Yes ☐ No ☐ Occupation: _____

If so, who is your provider? _____
What is your policy and group number? _____

Name of your Family Doctor: _____

Phone Number or Clinic Name: _____

Do you consent to your health team at Balanced Chiropractic contacting your medical doctor to discuss relevant information regarding your treatment plan? Yes ☐ No ☐

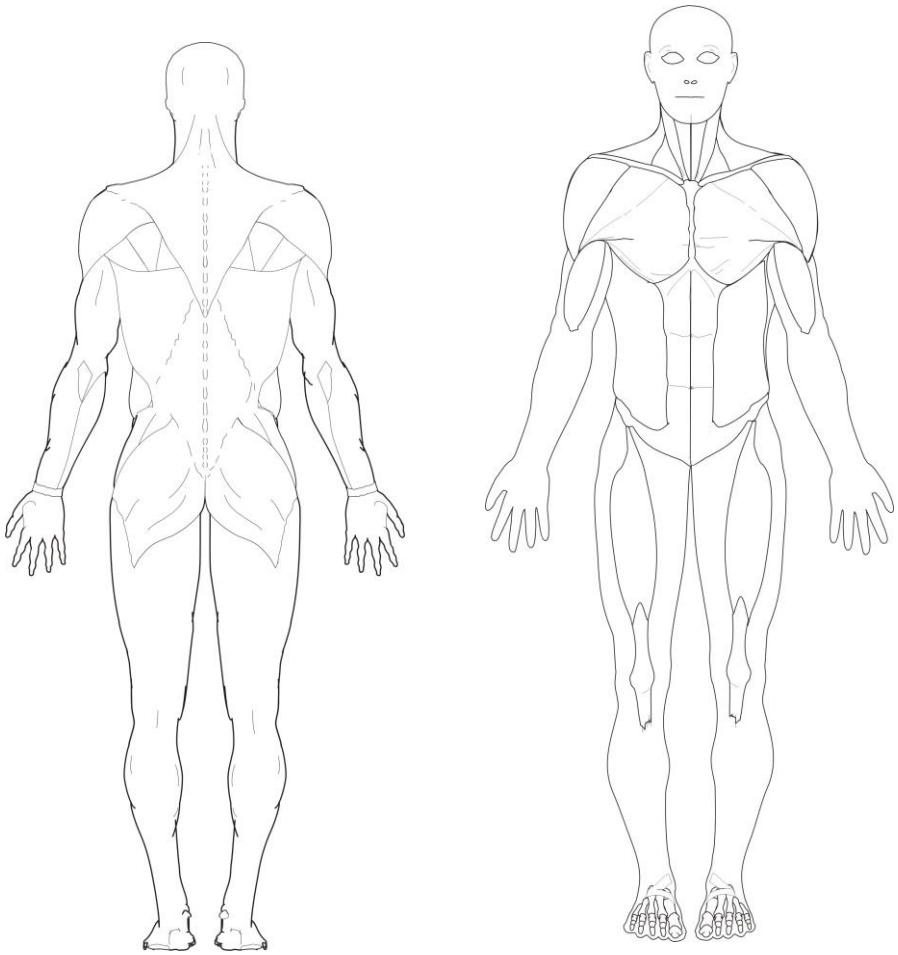
How did you hear about us?		Please write down the name of the person if selected		
Friends/Family	☐		Newspaper / Print Articles :	
Other	☐		Chamber Directory ☐	Fort Sask Guide ☐
Welcome Wagon	☐	Phone Book ☐	Farm and Friends ☐	Sturgeon Creek Post ☐

Please complete these forms on both sides

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Numbness: + + + + + Pins and needles: o o o o o Aching: [redacted]

Burning: x x x x x Stabbing: / / / / / / /



Please mark on the line below where you would describe your pain level today.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please see other side

Please check all answers and fill in the blanks where appropriate.

Reason for appointment:_____

When did your condition begin?_____

Have you ever had similar problems? ❑ yes ❑ no
Explain:_____

Have you had x-rays, MRI, or other tests for this condition? ❑yes ❑ no
If so, what kind of test and when?_____

Is your condition related to: Work? ❑ yes ❑ no
Has your employer been notified? ❑ yes ❑ no
Is this a WCB Claim? ❑ yes ❑ no
Motor Vehicle Accident? ❑ yes ❑ no
Date of Injury:_____
Is this a MVA Claim? ❑ yes ❑ no

Can you perform home activities? ❑ yes ❑ yes with help ❑ no
Can you perform work activities? ❑ all activities ❑ only some ❑ none

Please list any previous surgeries, illnesses, injuries (motor vehicle accident, etc):

_____
_____
_____

List all medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc):

_____
_____

Have you had previous chiropractic care? ❑ yes ❑ no Doctor:_____
Have you had previous acupuncture care? ❑ yes ❑ no Doctor:_____

Patient History

Have you ever had a serious fall(s) or injury(ies)?	❑ yes	❑ no
Have you ever been knocked unconscious?	❑ yes	❑ no
Have you ever been under treatment for cancer?	❑ yes	❑ no
Have you experienced any changes in weight in the last year?	❑ yes	❑ no
Do you have any health problems that you feel are not of interest to the doctor that you have not disclosed?	❑ yes	❑ no
Have you or any of your relatives ever suffered a stroke?	❑ yes	❑ no

Below is a list of diseases that may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect your course of treatment.

Please check all the following that you have been diagnosed with or told you have had:

❑ Rheumatic Fever ❑ Pleurisy ❑ Epilepsy ❑ Influenza ❑ Polio ❑ Arthritis
❑ Mental Disorders ❑ Diabetes ❑ Anemia ❑ Cancer ❑ TB ❑ Thyroid
❑ Chicken Pox ❑ Measles ❑ Mumps ❑ Pneumonia ❑ Blood Diseases
❑ Whooping Cough ❑ Small Pox ❑ Heart Disease ❑ Arteriosclerosis ❑ Eczema
❑ Bone spurs on the neck bones (cervical sprain)

Please check all the following you have experienced in the last 6 months:

❑ Visual disturbances (blurring, loss, double) ❑ Hearing disturbances (loss, ringing, etc)
❑ Slurred speech or other speech problems ❑ Loss of consciousness, even momentarily
❑ Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms or any other part of the body
❑ Sudden collapse without loss of consciousness ❑ Difficulty swallowing ❑ Dizziness

❑ Sore Throat
❑ Dental problems
❑ Ear Aches
❑ Painful or Excessive Urination
❑ Discolored Urine
❑ Prostate/Sexual Dysfunction

Please see other side

Please check all the following you have experienced in the last 6 months:

- ❑ Chest pain
- ❑ Heart problems
- ❑ Varicose veins
- ❑ Ankle swelling
- ❑ Lung problems/congestion
- ❑ Blood Pressure problems
- ❑ Constipation
- ❑ Multiple Painful Joints
- ❑ Walking problems
- ❑ Arm pain
- ❑ Joint stiffness
- ❑ Low back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ General stiffness
- ❑ Clicking jaw
- ❑ Weight problems
- ❑ Poor/Excessive appetite
- ❑ Excessive thirst
- ❑ Frequent nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Convulsions
- ❑ Hemorrhoids
- ❑ Abdominal cramps
- ❑ Heartburn
- ❑ Gas/bloating after meals
- ❑ Nervousness
- ❑ Paralysis
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Fainting
- ❑ Allergies
- ❑ Cold/tingling extremities
- ❑ Fatigue
- ❑ Loss of sleep
- ❑ Headaches
- ❑ Fever

Female Patients

- ❑ Bladder problems
- ❑ Menstrual irregularity
- ❑ Menstrual cramps
- ❑ Vaginal pain/infections
- ❑ Breast pain or lumps
- ❑ Other problems

Could you be pregnant? ❑ yes ❑ no Due Date:_____

Are you trying to conceive? ❑ yes ❑ no

Do you drink:	Coffee?	❑ yes	❑ no	_____cups per week
	Tea?	❑ yes	❑ no	_____cups per week
	Alcohol?	❑ yes	❑ no	_____drinks per week

Are you currently, or ever been, a smoker? ❑ yes ❑ no

From:_____ To:_____