Dr. Salima Ismail., B.Sc., B.S.S., D.C.
Dr. Victoria Clarke, B.Sc., D.C.
Chiromax of Manotick

Date: _____ Name: _____
Address: _____
City: _____
Postal Code: _____ Email:_____
Home Phone: _____ Business Phone: _____
Were you referred to our office? Yes □ No □
If yes, whom may we thank? _____
Date of Birth: _____ M □ F □
You Are □ Married □ Common Law □ Single □ Widowed □ Separated □ Divorced
Ages of Children: _____
Family Physician: _____
Report to family physician? _____
Please describe your chief complaint. _____
How did this condition develop? (What caused it? How did it start?)
_____
When did you become aware of the problem? _____
Have you had this or a similar problem before? □ Yes □ No If yes, please explain.
_____
Have you received treatment for this condition, Chiropractic or otherwise?
□ Yes □ No If yes, when and what were the results?
_____
Any medical diagnosis of your complaint? □ Yes □ No
If yes, please list diagnosis. _____
This problem is: □ getting better □ getting worse □ remaining the same
Is there anything you do that aggravates your condition?
How has this condition affected your life?

A. **At home:**
B. **Occupational:**
C. **Recreational:**
D. **Rest and Sleep:**

Have you ever been in an automobile accident? □ Yes □ No
Any other accidents or falls that may have caused or contributed to your problem?
_____
Have you had any other serious illness or surgeries? □ Yes □ No
If yes, list the year and the nature of the illness/surgery?
_____

Medication/Vitamins that you take: _____

NAME: **DATE:**

Please complete the following in order to provide us with your accurate health history. These problems may affect the course of the Chiropractic treatment.
Check any of the following you have had during the past 6 months:

□ Pneumonia	□ Mumps	□ Arthritis	INTAKE:
□ Rheumatic Fever	□ Chicken Pox	□ Epilepsy	□ Caffeine
□ Thyroid	□ Diabetes	□ Mental Disorder	□ Alcohol
□ Tuberculosis	□ Cancer	□ Measles	□ Tobacco
□ Whooping Cough	□ Heart Disease		□ Activity
□ Eczema			

Musculoskeletal System

□ Low back pain □ Pain between shoulders □ Neck pain □ Arm pain
□ Joint pain/Stiffness □ Walking problems □ Difficulty chewing/Clicking jaw
□ Shoulder pain □ Stiffness □ Whiplash injury

Genitourinary System

□ Bladder trouble □ Painful/excessive/discoloured urination □ Kidney problems

Nervous System

□ Nervous □ Numbness □ Paralysis □ Dizziness □ Forgetfulness
□ Confusion/Depression □ Fainting/Convulsions □ Cold/Tingling extremities
□ Stress □ Blurred vision □ Double vision

C-V-R System

□ Chest Pain □ Short breath □ Blood pressure problems
□ Irregular heartbeat □ Heart problems □Lung problems/Congestion
□ Varicose veins □ Ankle swelling □ Stroke/Relatives

General System

□ Fatigue □ Allergies □ Loss of sleep □ Fever □ Headaches
□ Slurred speech □ Difficulty swallowing

EENT System

□ Vision problems □ Dental problems □ Sore throat □ Earaches
□ Hearing difficulty □ Stuffed nose □ Ringing/buzzing in ears

Gastrointestinal System

□ Poor appetite □ Excessive appetite □ Excessive thirst □ Frequent nausea
□ Vomiting □ Diarrhea □ Constipation □ Haemorrhoids
□ Liver problems □ Gall bladder problems □ Weight gain/loss □Colitis
□ Abdominal cramps □Gas/Bloating after meals □ Heartburn
□Black/Bloody stool

Male/Female

□ menstrual irregularity □ menstrual cramping □ vaginal pain/infections
□ Breast pain/Lumps □ Prostate/Sexual dysfunction

Females Only: When was your last period?

Are you pregnant? □ Yes □ No

NAME: **DATE:**

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

Numbness	Pins and Needles	Burning	Aching	Stabbing
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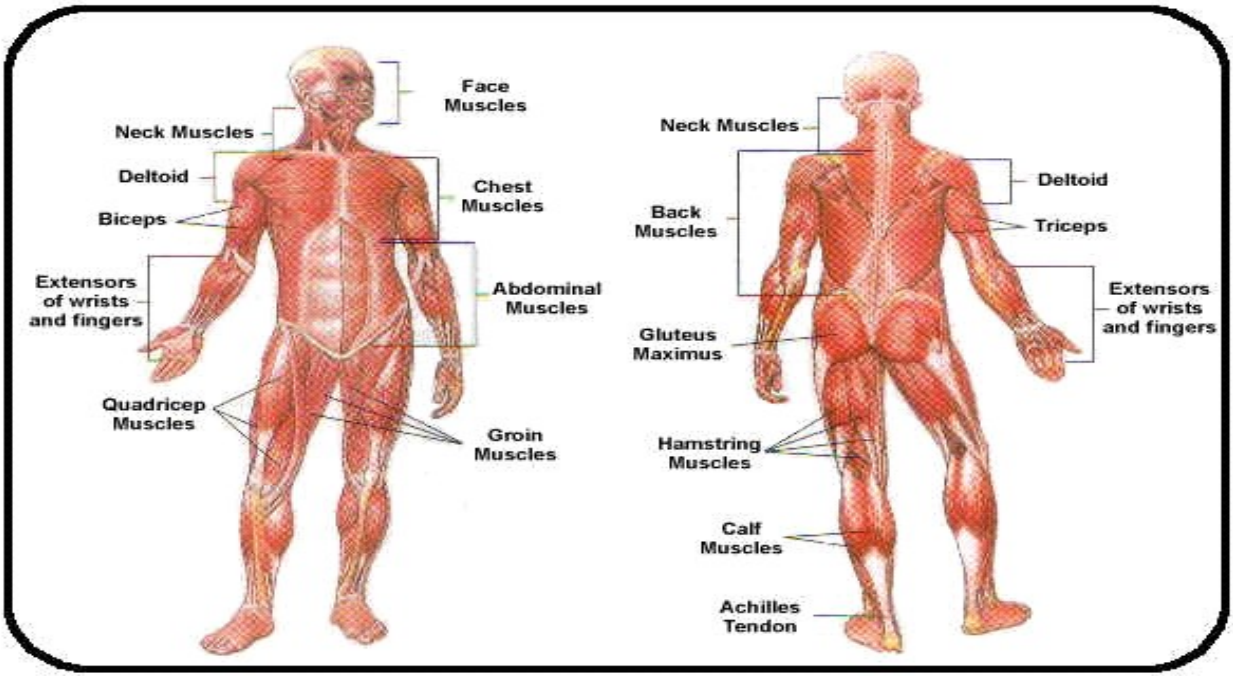
Pain Chart



Right **Left** **Left** **Right**

The line below represents pain intensity. Please mark an "X" at the position on the scale. This indicates how much pain <u>you feel at this time.</u>

0_____10

No Pain **Worst Pain Imaginable**