Patient Name _____File # _____

WELCOME

TO THE MILLER CHIROPRACTIC CLINIC

We are pleased that you have chosen to consult us regarding your health. In order to help us evaluate your condition thoroughly, please complete the following form. This information is important so we ask that you be accurate. Please ask for assistance if you are unsure of any aspect of the questionnaire.

NAME _____

ADDRESS _____

CITY _____**POSTAL CODE** _____

DATE OF BIRTH _____**HEALTH CARD** _____

CIRCLE: Single/Married/Widowed/Divorced/Separated. GENDER: M/F/Other

NO. OF CHILDREN _____ **SPOUSE'S NAME** _____

OCCUPATION_____

BUSINESS ADDRESS _____

TELEPHONE # HOME _____**BUSINESS** _____

EMAIL ADDRESS _____

REFERRED TO OUR OFFICE BY: _____

Patient Name _____File # _____

Please Complete all Pages – Thank-you

CURRENT HEALTH CONDITION

Area of main problem _____

_____

_____

When did this condition begin? _____

Is it getting: Better?____ Worse?____ Staying the same?____

Have you had this before? Yes____ No____ When?_____

What treatment did you receive? _____

From whom? _____

Cause of this condition? _____

_____

What aggravates your problem?_____

_____

What alleviates it? _____

Is the problem: Constant?_____Comes and Goes? _____

Do you sleep on your side? _____ back? _____ stomach?_____

Your medical doctor's name: _____

List ALL current medications: _____

_____

_____

List OTHER supplements (eg. Vitamins) _____

_____

_____

Other areas of complaint _____

_____

Have you been tested HIV Positive? Yes ___ No___ Not tested ___

Patient Name _____File # _____

How much of the following do you consume daily?

___Cups of coffee ___Cigarettes ___Cups of Tea ___Alcoholic beverages

Do you exercise daily? ___Yes ___No

PAST HEALTH HISTORY

List any surgery you have had, and the year you had it.

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Describe any bad falls or accidents _____

_____

_____

Have you been in a car accident? Yes___ No___ When?_____

Have you ever had Chiropractic care? Yes___ No___ If yes, when?_____

Doctor's name and address _____

For what condition?_____

Were x-rays taken? Yes___ No___ Not Sure___

Below are listed a number of conditions which may seem unrelated to the purpose of your appointment. However these questions must be answered carefully as these problems can affect the overall course of your Chiropractic care.

CIRCLE ANY OF THE FOLLOWING YOU MAY HAVE HAD:

Pneumonia	Mumps	Influenza
Polio	Small Pox	Pleurisy
Tuberculosis	Chicken Pox	Arthritis
Rheumatic Fever	Diabetes	Epilepsy
Whooping Cough	Cancer	Mental Disorders
Anemia	Heart Disease	Psoriasis
Measles	Thyroid Disease	Eczema

Patient Name _____File # _____

People go to Chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to correct the underlying cause of the problem, to increase their health potential and prevent the problem from returning. Please **circle** which type of care you are seeking:

CORRECTION or **RELIEF CARE**

CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULOSKELETAL

Low back pain
Pain between shoulders
Neck pain Arm Pain
Join pain/stiffness
Leg pain Jaw pain/clicking

NERVOUS SYSTEM

Numbness in arms/legs
Paralysis Dizziness
Forgetfulness
Confusion/Depression
Fainting Convulsions
Cold/Tingling arms or legs
Stress Headaches

GENERAL

Fatigue Allergies
Loss of sleep
Irritability Fever

GASTROINTESTINAL

Poor/Excessive appetite
Increased thirst
Nausea Vomiting
Diarrhea Constipation

GENITOURINARY PROBLEMS

Bladder trouble
Painful/Excessive urination
Discoloured urine

CARDIOVASCULAR PROBLEMS

Chest pain Shortness of breath
Stroke Varicose Veins
Ankle Swelling Irregular heartbeat
Blood pressure problems
Lung congestion/problems
Heart problems

EAR, EYE, NOSE, THROAT

Vision problems Dental problems
Sore throat Ear aches
Stuffy nose Sinus problems
Hearing difficult

MALE/FEMALE SYSTEMS

Menstrual irregularity/cramps
Vaginal pain/infection
Breast pain/lumps
Prostate/sexual dysfunction

FEMALES ONLY

Date of ONSET of last period

Patient Name _____File # _____

Hemorrhoids Colitis

Liver problems

Gall Bladder problems

Weight problems

Heartburn

Gas/Bloating after meals

Black/Bloody stool

_____

Are you pregnant? Yes _____

No _____ Not Sure _____

FAMILY

Has anyone in your family had a condition similar to yours?

____Yes ____No